Meeting the Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons

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—Bruce D. Emery, M.Ed., M.S.W., Director

Introduction to the *Cultural Diversity Series*

The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences and assessing the mental health system's success in addressing cultural differences.

As the 21st century approaches, state mental health agencies face the growing challenge of accommodating an increasingly diverse and evolving constituency. The call to provide appropriate and accessible mental health services to all consumers—regardless of color, ethnicity, national origin, language, race, religion, age, disability, gender, sexual orientation or socio-economic standing—challenges state mental health agencies to develop effective, culturally competent services and treatment methods. As the U.S. population changes dramatically, so does the public mental health system consumer base. Immigration is now the nation's major source of population growth. More than 1 in 4 Americans (27 percent) are non-white and/or Latino. By the year 2050, it is projected that nearly 1 in 2 Americans (47 percent) will be non-white and/or Latino.[1] Mental health staff may be unprepared for differences in language and world view, and even less prepared, for example, to support a gay inpatient consumer facing prejudice from other staff or residents or to provide crisis intervention to a deaf or otherwise disabled consumer. However, local and/or federal statutes may require appropriate service provision to these persons.

The *Cultural Diversity Series* attempts to provide basic information and guidelines regarding the needs of a variety of ethnic and non-ethnic minorities. Each of these technical assistance reports provides a synopsis of the particular population's mental health needs, relevant cultural characteristics and traditions, perceptions about mental illness and preferences for services and supports. Each report also describes several mental health programs that have successfully tailored their services to meet the needs of diverse consumers, and contains a comprehensive resource section with recommended readings, web sites and organizational resources.

The goal of the *Cultural Diversity Series* is to assist state mental health agencies in moving toward mental health service delivery systems that are appropriate and accessible to all consumers. Future reports will focus on the mental health needs of Asians and Pacific Islanders, Hispanics/Latinos, Native Americans and persons who are deaf. The first report, *Meeting the Mental Health Needs of African Americans*, is available directly from NTAC.

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[1] U.S. Bureau of the Census. (1996, May). *Resident Population of the United States: Middle Series Projection, 1996-2000 by Sex, Race and Hispanic Origin, with Median Age*. Washington, DC: Population Division, U.S. Bureau of the Census.

Disturbing Service Utilization Trends

Despite their growing numbers, members of ethnic and racial groups are often underserved or inappropriately served by the public mental health system. Research suggests that various ethnic groups underutilize mental health services, either by dropping out of services or by entering services at much later stages in their illness, thereby creating a need for more costly services.[2] [3] For example, studies have found that although African Americans, Native Americans and Hispanics in most states underutilize community-based services, they are significantly overrepresented in state inpatient facilities.[4]

Little is known about the patterns of utilization of mental health services by sexual minorities (gay men, lesbians, bisexuals and transgendered persons). However, discrimination in mental health settings has been documented, as has the tendency of lesbian and gay youth (who are at high risk for substance abuse and suicide) to conceal their sexual orientation from health care providers.[5] One major national survey found that 73 percent of lesbian respondents had pursued counseling services at some time, most frequently for feelings of sadness or depression.[6]

In anticipation of increased future service demands by growing ethnic minority populations, state mental health agencies are increasingly examining their accessibility to both ethnic and non-ethnic minorities. State mental health agencies may be able to reduce the use of costly inpatient services by engaging ethnic minorities during earlier stages of their mental illnesses. More important, by providing culturally competent community-based services to all minorities, mental health decision-makers can minimize human distress.

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[2] Lefley, H.P. (1990). "Culture and Chronic Mental Illness," *Hospital and Community Psychiatry* 41(3): 277-286.

[3] Munoz, F. U., and Endo, R. (Eds.). (1982). *Perspectives on Minority Group Mental Health*. Washington, DC: University Press of America.

[4] Aponte, H.J. (1994). *Bread & Spirit. Therapy with the New Poor: Diversity of Race, Culture and Values*. New York: W.W. Norton.

[5] Gay, Lesbian, Bisexual and Transgender Health Access Project. (1997). *Health Concerns of the Gay, Lesbian, Bisexual, and Transgender Community. (2nd Ed.)*. Boston: Massachusetts Department of Public Health.

[6] Bradford, J., Ryan, C., and Rothblum, E.D. (1994). "National Lesbian Health Care Survey: Implications for Mental Health Care," *Journal of Consulting and Clinical Psychology 62:* 228-242.

Cross-Cultural Mental Health Services and Barriers to Service Delivery

Culture encompasses "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group."[7] Cross-cultural mental health service delivery occurs whenever two or more of the participants are culturally different. Thus, the term could be applied, for example, to "a counseling dyad consisting of a low-acculturated Mexican American client and a high-acculturated Mexican American counselor."[8] Similarly, a married heterosexual service provider brings a vastly different worldview and set of experiences to the counseling relationship than a single lesbian client. Policymakers and service providers are coming to understand that cultural diversity must be broadly defined to accommodate wide variations among consumers.

Cultural differences exist on many levels, including help-seeking behaviors, language and communication styles, symptom patterns and expressions, non-traditional healing practices and the role and desirability of medical intervention.[9] [10] Members of ethnic and non-ethnic minorities may be underserved by the public mental health system for varied and complex reasons. Some commonly cited factors include:

- the stigma of mental illness and the varying ways that members of different ethnic minority groups may define mental health and mental illness;
- lack of culturally appropriate services to accommodate the needs and beliefs of diverse consumers;
- consumer fears of experiencing discrimination in the treatment setting;
- mental health providers' lack of awareness or knowledge regarding culturally appropriate policies and practices;

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[7] Cross, T.L., Bazron, B.J., Dennis, K.W., and Isaacs., M.R. (1989). *Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who are Seriously Emotionally Disturbed.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Development Center.

[8] Atkinson, D.R., Morten, G., and Sue, D.W. (1998). "Racial/Ethnic Minorities and Cross-Cultural Counseling." In Atkinson et al. (Eds.) *Counseling American Minorities.* New York: McGraw-Hill. p. 17.

[9] Comas-Diaz, L., and Griffith, E.E. (Eds.). (1988). *Clinical Guidelines in Cross-Cultural Mental Health.* New York: Wiley.

[10] Gaw, A.C. (Ed.). (1993). *Culture, Ethnicity and Mental Illness.* Washington, DC: American Psychiatric Press.

- language barriers increased by the growing numbers of both consumers and providers whose native language is not English;

- communication barriers based on differences in verbal and nonverbal styles that may lead some minority consumers to feel they have given very clear messages to providers who have not understood the communication;

- lack of familiarity with Western or mainstream mental health services;

- fear of exposure or discomfort about disclosing sexual orientation or gender identity concerns to service providers; and

- systemic barriers, such as funding sources that place strict limits on reimbursable services.

Special challenges may be present in the case of consumers who are refugees or whose native language is not English; both of these groups may exist within all of the communities addressed in the *Cultural Diversity Series.* For a fuller discussion of needs and barriers to service faced by consumers who are refugees or are non-English speaking, see the sidebars on pages 6-7.

Cultural Competence

Developing cultural competence within a mental health system is a dynamic and evolutionary process.[11] The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences and assessing the mental health system's success in addressing cultural differences. A culturally competent approach to services requires that agencies examine and potentially transform each component of mental health services, including assessment, treatment and evaluation.

Developing respect for differences and cultivating successful approaches to diversity requires increased awareness—of one's self; of unstated institutional cultural norms; and of the history, culture and needs of diverse consumers. To increase cultural competence, mental health service providers need to develop an awareness of their own racial and cultural heritage; to understand

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[11] In *Building Bridges, Tools for Developing an Organization's Cultural Competence* (see Miller et al. in suggested readings), the authors identify six stages of developing cultural competence:

Stage 1 Sees other cultures as inferior: seeks to destroy other cultures.
Stage 2 Cultural incapacity: adopts paternalistic posture toward so-called inferior people.
Stage 3 Cultural incapacity: seeks to assimilate differences, ignore strengths.
Stage 4 Cultural precompetence: realizes weaknesses and makes commitment to improve.
Stage 5 Culturally competent: respectful, accepting, self-monitoring.
Stage 6 Takes advocacy and educational role.

how that heritage influences their understanding and biases about normality/abnormality and the process of mental health service delivery; and to understand the significant impact of differences both in language and in verbal and nonverbal styles on the process of communication.[12] Mental health systems typically operate on unstated Western principles—such as, for example, the primacy of the individual over the group, a focus on competition and achievement, separation of the mind and body and devaluing of altered states of consciousness—which may be at odds with the underlying values and beliefs of some ethnic and racial populations. Without awareness of this dynamic, mental health providers may impose this Western framework on minority consumers.

The populations that are the subject of these reports have all experienced and/or are experiencing some form of social inequity that is directly relevant to their status as underserved groups. Exploring and sometimes challenging the assumptions and biases held by stakeholders and the wider community is a crucial step toward achieving a culturally competent system. These attitudes have a direct impact on the functioning of minorities, their mental health needs and their willingness to seek services. Similarly, cultural assumptions affect the mental health system, its practitioners and its ability to engage minorities.

Some mental health systems and providers seeking to increase cultural awareness may inadvertently rely on overgeneralizations that ignore subgroup and individual variation, thus belying the basic value of cultural competence. To be truly culturally competent, mental health systems must be aware of significant differences in lifestyle and worldview among diverse populations, while valuing and responding to the distinct needs of each client. Rather than relying on stereotypes about groups, administrators and practitioners need to be aware of their own cultural assumptions and to ask consumers how *they* understand their problems and what *they* need.

These reports are designed to help key decision-makers wrestle with the challenges facing public mental health systems, while effectively addressing the need for individualized, culturally competent services for ethnic and non-ethnic minorities.

[12]Atkinson et al., op. cit.

A closer look at: Refugees

People seeking refuge in the United States come from all ethnic and racial backgrounds and often have great difficulty obtaining traditional mental health services. These individuals have often experienced severe stress, resulting from continuous threat to life or freedom, traumatic flight, death of family members or friends, torture and imprisonment, living in concentration or refugee camps, uncertainty and lack of control over relocation and inability to return to their homeland.[13] Their mental health may be jeopardized by multiple losses (of country, family, status) and other major disruptions (e.g., unemployment) which often accompany resettlement in a new country. A proportional number can be expected to be sexual minorities, or deaf or disabled, and the meaning and impact of these attributes will vary widely by culture.

Unfortunately, definitive prevalence rates of mental illness among refugees are elusive. The few studies available reveal that depression, anxiety and post-traumatic stress disorder are reported at disproportionately higher rates in refugee populations. In addition, a small percentage of refugees experience schizophrenia or brief reactive psychoses marked by delusional content strongly related to culture which may require prolonged, intensive intervention.[14] Typically, SMHAs have contact with refugees during times of crises through crisis counseling services or inpatient treatment. Successful strategies to engage refugees prior to the eruption of crises include:

- networking with and through the refugee community;
- conducting home visits;
- linking with physical health services;
- using bicultural professional and paraprofessional staff; and
- making outreach efforts that focus on helping refugees meet basic needs, such as housing and income.

Such services are accepted more easily when linked with resettlement agencies (e.g., religious-based organizations, private organizations, state agencies or ethnic organizations that assist individual refugees upon arrival) and mutual assistance associations in which former refugees and immigrants help their own people. The Center for Mental Health Services' Office of Refugee Mental Health serves as a bridge between the mental health and refugee communities, providing consultation and training to states and refugee organizations.

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[13] Garcia-Peltoniemi, R.E. "Clinical Manifestations of Psychopathology." In Westermeyer, J., Williams, C.L., and Nguyen, A.N. (Eds.) (1991). *Mental Health Services for Refugees*. Washington, DC: U.S. Government Printing Office.

[14] Ibid.

A closer look at: Non-English Speaking Consumers

The challenge of developing culturally competent mental health services is complicated by the vast number of languages that are spoken in the United States. Mental health providers may have difficulty reaching, communicating with and treating non-English speaking and/or deaf consumers, who exist within all communities.

Ideally, bilingual mental health professionals will be available to engage and provide treatment to people whose primary language is other than English. However, the need for academically trained, multilingual and multicultural mental health professionals far exceeds the number now available. While increasing the numbers of these professionals is essential, other models of services are also in use, including:

***Bilingual Paraprofessionals**. While they may not have formal clinical training, bilingual workers serve many valuable functions, including translator, paraprofessional counselor, culture broker, outreach worker, community educator, community advocate and trainer of service providers about the refugee's culture.[15] Ultimately, the goal may be to encourage bilingual workers to obtain further academic training in mental health to increase the supply of bilingual and bicultural psychiatrists, psychologists, social workers and other mental health professionals.

Interpreters. Using interpreters for assessments and treatment is a less desirable route, but one that many systems rely upon given the shortage of bilingual mental health professionals. As Adkins noted, "A facility with language does not make a person an effective interpreter unless there has been adequate training, agreement on interpretation system, and building of rapport between the mental health professional and interpreter."[16] Thus, relying on family members to serve as interpreters is considered inadequate and inappropriate.

**Persons who can communicate in a spoken language and in American Sign Language are considered bilingual.*

[15] Egli, E. (1987). *The Role of Bilingual Workers Without Professional Mental Health Training in Mental Health Services for Refugees.* Minneapolis, MN: Department of Psychology, University of Minnesota.

[16] Adkins, M.A. (1990). "Role of Bilingual/Bicultural Service Providers in the Delivery of Mental Health Services." In Holtman, W.H., and Bornemann, T.H. (Eds.) *Mental Health of Immigrants and Refugees - Proceedings of a Conference Sponsored by Hogg Foundation and World Federation for Mental Health,* Austin, TX: Hogg Foundation for Mental Health.

Executive Summary

People who are gay, lesbian, bisexual and transgender (GLBT) represent a substantial minority of the U.S. population, yet pervasive prejudice and stigma often inhibit the development and provision of appropriate services for them. This report provides basic information regarding common mental health concerns of GLBT persons to aid in the development of culturally competent mental health services and supports.

Sexual Minority Identity Development

Not all GLBT individuals are at the same stage of self-acceptance and identity development; some may be afraid or ashamed of their feelings while others are quite comfortable with themselves and with publicly disclosing their sexual minority status. Skilled mental health interventions with gay, lesbian or bisexual consumers include an assessment of where the individual is in the process of identity development and an awareness of how their stage in development affects their mental health, stress levels, self concept and access to social supports. Sexual minority individuals who are also ethnic minorities often experience a "dual oppression" that requires that they cope with racism as well as homophobia; GLBT persons with mental illness experience similar dual stigmatization.

Special Concerns of GLBT Youth

Providers and agencies must be aware of the special needs of GLBT youth, who face complex developmental tasks in an atmosphere that often includes isolation, hostility, prejudice and potential danger. They may be the targets of harassment from both peers and adults. As a result, GLBT youth are more likely to attempt suicide than their heterosexual peers, more likely to be victims of violence, and are disproportionately represented among homeless and runaway youth.

Prevalence and Effects of Violence Against Sexual Minorities

The prevalence and social acceptance of prejudice and violence against sexual minorities impose unique stressors on their mental health and well being. One study estimates that 40 percent of gays have been victims of violence because of their sexual orientation and that family members were responsible for this violence in 49 percent of the cases. Hate crimes against transgender persons tend to be more severe and more often lead to murder. Effects of such victimization may include lowered self-esteem, shame, guilt, depression, school-related problems, running away and homelessness, post-traumatic stress, substance abuse and suicide.

Substance Abuse

Research findings vary on rates of alcohol and drug abuse among lesbians and gay men, but experts maintain that drug and alcohol abuse are significant health and mental health concerns for sexual minorities. One study found that lesbians and gay men were twice as likely to be moderate drinkers, but about equally as likely to be heavy drinkers, as heterosexuals. Experts note the likelihood of a link between internalized homophobia, low self-esteem, ongoing discrimination and increased use of alcohol and drugs. GLBT consumers who seek treatment for substance abuse problems may encounter barriers to treatment in unsupportive service settings.

Suicide

One study found that lesbian, gay or bisexual students and those who had had same-sex experiences were four times more likely to have attempted suicide than heterosexual students. Ethnic minority gays and lesbians may be at higher risk for suicide attempts than white gays and lesbians. Heterosexual youth who have been victims of anti-gay harassment also have shown higher rates of suicide attempts, suggesting a direct relationship between discrimination and self destructive behaviors. Several factors are associated with higher risk for attempting suicide, including coming out at a younger age, loss of others to suicide, gender identity concerns, rejection due to sexual orientation, and substance use or abuse.

Transgender Concerns

Some individuals choose to challenge societal norms regarding sex roles, but do not question their own anatomical gender. Transsexuals are persons with a persistent sense of schism between their anatomical sex and their felt gender identity; they typically report gender identity confusion dating from as early as age 3 or 4. Transgendered persons often suffer lifelong persecution and misunderstanding. They may seek therapy for a variety of reasons, including depression, suicidal thinking, and a range of complex feelings related to their gender identity concerns, or to pursue comprehensive assessment, diagnosis, and referral for medical treatments.

HIV and AIDS

AIDS is a highly stigmatized illness that disproportionately affects a variety of populations already stigmatized or underserved within the United States. Experts note that the uniquely stressful impact of the slow and progressively debilitating nature of HIV infection changes the mental health needs of infected persons at different phases of the illness; a model is offered for understanding these transitions. Clients with HIV express a number of common concerns, such as issues related to illness, sexuality, grief, isolation, or death and dying. Many of these can be challenging to providers; it is important that providers and agencies develop strategies for avoiding provider "burnout." Some special HIV concerns affecting sexual minorities include the

effect of widespread loss and multiple bereavements on the GLBT community, and the unique needs of HIV-negative gay men.

Model Programs

The report concludes with profiles of model programs providing culturally competent mental health services to gay, lesbian, bisexual and transgender consumers. Each profile describes the program's philosophy and values, services and supports, funding sources and available evaluation data. The three programs featured are:

- Seattle Counseling Service for Sexual Minorities, which has been in operation since 1969 and was the first mental health agency in the United States to specifically serve the unique needs of this population;

- Heights Hill LesBi-Gay and Transgender Affirmative Program at the South Beach Psychiatric Center, a New York State Office of Mental Health facility; and,

- Pride Institute, a nationally recognized private substance abuse and mental health treatment program specially designed to address the needs of sexual minorities.

Gay, Lesbian, Bisexual and Transgender Health Care Consumer Bill of Rights*

Gay, lesbian, bisexual and transgender people of all ages have the right to full and equal access to all health care services, in a supportive environment, where it is safe for them and for their families to be out to their providers if they choose to do so. They have the right to health care services that are comprehensive, medically appropriate and culturally competent. In order to ensure their access to quality health care, gay, lesbian, bisexual and transgender people of all ages have the right:

1. To confidentiality of their medical records, including confidentiality about their sexual orientation and gender identity;

2. To have their families recognized, acknowledged and respected by all health care providers;

3. To be treated in a health care environment that uses culturally appropriate language, including culturally appropriate intake and other written forms;

4. To have case management and treatment plans that include and address sexual orientation and gender identity where it is a necessary and appropriate issue in client care;

5. To be included and have their needs addressed in prevention and other public health programs;

6. If a minor, to safe and confidential medical treatment, to be informed of their legal rights, and to be advised of the possibility and possible consequences of mandated reporting.

* *This Bill of Rights was produced by the Gay, Lesbian, Bisexual and Transgender (GLBT) Health Access Project. Founded in 1995, GLBT Health Access Project is the result of a unique collaborative effort between community-based agencies and the Department of Public Health in Massachusetts with the goal of developing comprehensive, culturally appropriate health care services and health promotion policies for GLBT people. The project is currently located at JRI Health division of the Justice Resource Institute in Boston, and is funded primarily by the Massachusetts Department of Public Health. Further information on GLBT Health Access is available in the Resource Section.*

Meeting the Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons

Introduction

Although gay men, lesbian women, and bisexual and transgendered persons may represent a substantial minority of the general population, stigma associated with their lifestyles often inhibits the development and provision of adequate and appropriate mental health services for this population. Most major psychological, psychiatric and medical professional associations have called upon their members to take an active role in providing accurate information and appropriate services to combat discrimination against lesbians and gays and decrease risk factors facing this population related to their safety, health and mental health. Almost twenty-five years ago, for example, the American Psychological Association (APA) urged mental health professionals "to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations" and deplored "all public and private discrimination ... against those who engage in or have engaged in homosexual activities" (Conger, 1975, p. 633).

This report provides basic information regarding the mental health needs of people who are gay, lesbian, bisexual or transgender (GLBT) to aid in the development of appropriate and accessible mental health services and supports. The report begins with definitions of terms and categories important to a discussion of GLBT concerns and then addresses several special areas of mental health concern for this population. These areas, which were determined by a review of the literature and of recommendations from agencies serving this community, include:

- Sexual minority identity development,
- Special concerns of GLBT youth,
- Prevalence and effects of violence against sexual minorities,
- Substance abuse,
- Suicide,
- Transgender concerns, and
- HIV and AIDS.

Following brief discussions of each area are recommendations for appropriate interventions based on the information presented. Consistent with NTAC's commitment to provide practical program information and guidance, the report also includes descriptions of three innovative programs developed to better serve the needs of GLBT consumers. Suggested readings, agency resources and web sites related to cultural competence in mental health service delivery are included following the bibliography.

Terminology and Prevalence

Sexual minority persons represent all races, ethnicities, religions and social strata. Studies have shown no significant difference in rates of psychological adjustment or psychopathology between homosexual and heterosexual populations.

The term *sexual minority* refers to gay men, lesbian women and bisexual and transgendered persons. These groups are considered to be "minority" because of several commonalties with other minority groups—including separate cultural norms, idiosyncratic use of language and terminology, and the reality of being discriminated against because of their social minority status.

Estimating the number of sexual minority persons in the population is extremely difficult due to a variety of complicating factors. Lack of funding for research has been one impediment. When research is conducted, responses to surveys are affected by the intent and sampling methods of researchers and by the legitimate fear of discrimination that may influence GLBT persons' willingness to participate. Statistics are also affected by distinctions between behavior, desire and identity that make it hard to define "homosexuality" or "bisexuality." In various studies, for example, between 13 percent and 18 percent of women and 21 percent and 37 percent of men have reported same-sex attractions or behaviors, with much smaller percentages (2% to 9%) reporting exclusive homosexuality. (See Ryan & Futterman, 1998, for a full discussion.)

Sexual minority persons represent all races, ethnicities, religions and social strata. Studies have shown no significant difference in rates of psychological adjustment or psychopathology between homosexual and heterosexual populations (Gonsiorek, 1982, 1991). Thus using an estimated proportion of 4 percent of the population and applying it to the approximation that five million Americans suffer from mental illness each year (Health Care Reform for Americans with Severe Mental Illness, 1993, cited in Hellman, 1996), we can estimate that some 200,000 or more Americans with mental illness are members of a sexual minority.

Defining Terms—*What words do we use to talk about sexual minorities?*

Sexuality is composed of biological sex, sex role, gender identity and sexual orientation (APA, 1998).

- *Biological sex* refers to anatomical sex at birth.

- *Sex role* refers to adherence to cultural norms regarding femininity and masculinity. Despite common stereotypes about gays and lesbians, sex role is independent of sexual orientation.

- *Sexual orientation* refers to a complex web of emotions, behaviors, fantasies, attitudes and attractions. There are three possible sexual orientations: heterosexual, homosexual and bisexual (attracted to both males and females).

    - *Homosexual* has been criticized as a term because of its sole emphasis on sexuality, given that sexual orientation covers an array of feelings, thoughts, identifications and behaviors (Fassinger, 1991).

    - *Gay* is the term generally preferred by members of this population, although it is often thought of as referring to men only.

    - *Lesbian* is the preferred term of many same-sex-oriented women.

- *Gender identity* is a person's psychological sense of being male or female, and may be different from the person's biological sex.

    - *Transgender* is often used as an umbrella term to refer to a broad range of behaviors that challenge social sex-role stereotypes. It may also be used more specifically to refer to individuals who feel their gender identity is at odds with their biological sex; these persons are also called transsexuals.

    - *Transsexual* refers to persons who meet the diagnostic criteria of having "a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex" (APA, 1994, p. 533). Transsexuals may be male or female, and may be of any sexual orientation. These individuals often report that they began experiencing profound discomfort or unhappiness regarding their gender—known as *gender dysphoria*—as early as age 3 or 4 (Anderson, 1998).

Two other terms are helpful in understanding the counseling needs of this population:

- *Homophobia* is described as "the fear and hatred that characterizes reactions to gay people" (Fassinger, 1991, p. 159). Homophobia is seen as a motivating factor in hate crimes directed against sexual minorities.

    - *Internalized homophobia* describes the negative feelings that gay, lesbian or bisexual individuals may have about their own sexual orientation. Gay men and lesbian women are raised with the same prejudices as other members of society

and may face a significant struggle in coming to terms with their own identity. Many of the mental health issues discussed below—such as substance abuse and high rates of suicide attempts— may be related to struggles with internalized homophobia.

- *Heterosexism* refers to both bias against gays and to the tendency to assume that all persons are heterosexual. An example of heterosexism is the practice of asking at intake into a community mental health program whether a consumer is or has been "married." Marriage is not legal for gays and lesbians; thus the question both denies the life reality of a large number of consumers and may fail to elicit accurate information regarding partnership status. Gay, lesbian or bisexual consumers may hear this question as the kind of cue that is considered in assessing whether a setting is safe for or aware of sexual minorities.

Unique Characteristics as a Minority

A unique characteristic of sexual minorities is that members are not usually raised in households with other members of the same minority group. Because lesbian and gay children, for example, are generally raised by heterosexual parents, their parents may not be able to teach them important lessons about coping with discrimination and persecution as do parents of ethnic/racial minority children (Fassinger, 1991). Families may, in fact, become active sources of rejection, prejudice and even violence against the sexual minority child trying to come to terms with his or her identity (Savin-Williams, 1994). This may have particular impact on sexual minority persons with severe psychiatric concerns, because persons with mental illness are often significantly dependent on the support of families and treatment settings (Hellman, 1996). Sexual minority consumers often face homophobic bias in both places.

The number of families headed by lesbian or gay parents is growing steadily, and the parents and children in these families also face unique challenges. The parental relationship may not be recognized or supported by schools or social service agencies, which may create tension and isolation for children in these families and may interfere with provision of appropriate services for them.

Another unique experience for sexual minorities is related to their invisibility to others. Fassinger (1991) calls gays and lesbians "the hidden minority," noting that this invisibility is enhanced by active discrimination, which can make visibility a source of danger. This hidden status engenders a developmental process in which individuals must come to terms with unwanted or unwelcome aspects of the self that are judged or condemned by society and must attempt to integrate these feelings into their self-concepts and their lives. The process of acknowledging and coming to terms with these feelings is sometimes known as *coming out* or as sexual minority identity development. This process will be discussed in the next section of this report.

Implications for Mental Health Care

- Appropriate understanding of commonly used terminology will indicate to GLBT clients an awareness of their self-definitions and possible sensitivity to their life styles and needs.

- Mental health agencies and providers play a particularly important role in disseminating accurate information about GLBT persons in order to dispel myths about this population, some of which were fostered by mental health professions in the past.

- An understanding of heterosexism can help mental health systems undo bias in intake and assessment procedures and instruments, and in treatment planning and delivery. This understanding can help increase provider awareness of the presence of GLBT consumers and of their treatment needs.

- Hellman (1996) recommends that all consumer assessments include questions regarding consumer sexual self-identification, behaviors, and level of congruence between behaviors and identity. He also suggests exploring to what degree a consumer's sexual orientation has been a source of conflict with family and friends, or in prior treatment settings.

Sexual Minority Identity Development

Skilled mental health interventions with gay, lesbian or bisexual consumers include an assessment of where the individual is in the process of identity development and an awareness of how their stage in development affects their mental health, stress levels, self concept and access to social supports.

Gay and Lesbian Identity Development

Several authors emphasize that it is important for providers to have an understanding of the "coming out" or identity development process in order to develop appropriate and sensitive services for sexual minority clients (e.g. Clermont & Sioui-Durand, 1997; McCarn & Fassinger, 1996; Ryan & Futterman, 1998; Shannon & Woods, 1991). Not all GLBT individuals are at the same place in the process of self-acceptance and identity development. Some gays or lesbians, for example, may be aware of same-sex attractions but afraid or ashamed of them; these individuals may be more prone to isolation or depression. Some may have long-term partners but may never have disclosed their sexual orientation to family members. Some individuals may be fully self-accepting and comfortable disclosing their sexual orientation to others. In inpatient settings, the first group may experience extreme isolation, where the latter may risk being the targets of homophobia (Hellman, 1996). Models of lesbian/gay/bisexual identity development attempt to describe common paths through the maze of coming to terms with homoerotic desire and with the resulting changes in self-concept and social status (e.g., Cass, 1979; Coleman, 1982; McCarn, 1991; McCarn & Fassinger, 1996; Troiden, 1989).

Skilled mental health interventions with gay, lesbian or bisexual consumers include an assessment of where the individual is in the process of identity development and an awareness of how their stage in development affects their mental health, stress levels, self concept and access to social supports. Providers should also be aware that this identity development process usually occurs in the absence of adequate support systems, with few or no role models, lack of legal protection, and, for GLBT members of some racial/ethnic groups, an added fear of potential loss of primary racial/ethnic community support (Fassinger, 1991). Yet, despite the pressure of extreme stigma, societal disapproval, and absence of support or affirmation the vast majority of GLBT individuals successfully negotiate sexual identity development and lead productive and fulfilling lives. Research indicates that development of a positive gay/lesbian identity is linked to improved mental health and self-esteem (APA, 1998; Miranda and Storms, 1989, cited in Fassinger, 1991).

One of the first and most widely cited models of gay and lesbian identity development was created by Vivian Cass (1979) based on her clinical work and on theories regarding interpersonal

congruency and ethnic minority identity. She posits six stages, from *identity confusion* to *identity synthesis*, that are outlined in the box below.

Stages in the Development of Gay/Lesbian Identity
Vivienne C. Cass, 1979

Identity Confusion —
in which previously held assumptions about one's sexual orientation come into question;

Identity Comparison —
involving a sense of alienation from previously held views and from heterosexuals, accompanied by feelings of isolation and of not belonging;

Identity Tolerance —
characterized by tolerance, without full acceptance, of one's homosexuality. Individuals in this stage may actively pursue the company of other gay people but may separate their private and public lives;

Identity Acceptance —
characterized by a growing legitimization of sexual minority status and selective disclosure of sexual orientation to others;

Identity Pride —
involving feelings of pride and anger, open disclosure to others, immersion in the gay/lesbian subculture and the rejection of heterosexual values and institutions;

Identity Synthesis —
where one moves beyond viewing the world in terms of a gay/nongay dichotomy, and homosexual identity becomes one aspect of a more integrated self.

Most models follow a similar progression and describe a process of transformation in which same-sex attraction begins as a hidden, suppressed or marginalized aspect of identity. With growing awareness it eventually becomes a central concern, with tremendous impact on choice-making and life decisions. Access to gay and lesbian people, literature, music and organizations may be very important for modeling the possibility of a fulfilling life in this phase of development, and having a lesbian and gay support system contributes to better overall adjustment (Kurdek, 1988). Following this period of deep negotiation of minority status, gay or lesbian identity eventually moves back to a less central but fully integrated—rather than marginalized—aspect of the total self. McCarn and Fassinger (1996) have noted that there are really two developmental processes occurring simultaneously. One is an internal process related to accepting and actualizing ones own sexual orientation; the other occurs because same-sex attractions automatically place the individual in an oppressed group. Models of gay/lesbian/bisexual identity development are, in part, frameworks for a process of coping with discrimination.

Bisexual

Until recently, bisexuality has been subject to a separate stigma and misunderstanding from that of homosexuality. Many young people becoming aware of homoerotic preferences may for some time identify as "bisexual" due to both uncertainty about their developing identity, and to fear of the stigma associated with homosexuality. "Bisexual" may ultimately become an accurate expression of their adult sexual/affectional orientation, but it may also represent a phase in the process of coming to terms with homosexuality. Because of this second possibility, the term "bisexual" has been viewed with suspicion by homosexuals and heterosexuals alike. This has affected the identity development process for bisexual persons, many of whom may have felt pressured to adopt either a heterosexual or homosexual identity. Of the models discussed above, only McCarn and Fassinger (1996) address the possibility that an individual can cycle through sexual minority *identity awareness, exploration* and *deepening commitment* and arrive at a self-definition of bisexuality.

Transgender

No model was found of the development of transgender identity that is comparable to those for gay/lesbian identity development. More attention is paid in the transgender literature to differential diagnosis because both transvestitism and transsexualism are current mental health diagnostic categories, and treatment interventions are significantly determined by diagnosis. The developmental process of embracing awareness and acceptance of self may be similar to that experienced by lesbians and gays, but the degree of social stigma and discrimination are more intense for this population. It is possible that the reason no developmental model of transgender identity exists is because little attention has been given to this population in the professional mental health and social sciences communities. Some experts note that the lack of training of both health and mental health providers usually puts transgender consumers in the unfortunate position of educating their providers.

Dually Oppressed: Ethnic-Minority GLBT Individuals

Racism within the lesbian and gay community, and homophobia within some ethnic-minority communities, complicate the tasks of dealing with dual-oppression for ethnic-minority GLBT persons. Greene (1994) notes that many ethnic minorities display stronger disapproval of homosexuality than the dominant "Anglo community," which may result in greater pressure on gay and lesbian ethnic-minority group members to remain in the closet; yet attachments to their ethnic communities remain very important to many lesbians and gays. Ethnic-minority GLBT individuals may also face discriminatory treatment at gay and lesbian businesses and events (Greene, 1994).

Two studies of ethnic-minority gays and lesbians found that African-American and Asian-American gays and lesbians felt little support for their sexual orientation in their ethnic minority communities, and little support for their ethnic identity in the predominantly white gay and lesbian community (Loiacano, 1989; Chan, 1989). Research participants expressed a need to find life contexts in which both of these identities could be simultaneously validated. Greene notes, "Ethnic minority gay men and lesbians frequently experience a sense of never being part of any group completely leaving them at greater risk for isolation, feelings of estrangement, and increased psychological vulnerability" (1994, p. 249).

Dually Stigmatized: GLBT Individuals with Mental Illness

Similar to the struggles for ethnic minorities noted above, GLBT mental health consumers are often isolated within the GLBT community because of their mental illness and within the treatment setting because of their sexual orientation or gender identity (Ball, 1994; Hellman, 1996). These individuals must cope with the effects of their psychiatric symptoms while negotiating the dual stigmas of mental illness and minority sexuality or gender identity. This may occur at a particularly vulnerable point chronologically, since the consolidation of sexual identity often occurs in the same period of life in which severe psychiatric illness may first manifest.

Ball (1994) describes the process of working through institutional barriers to develop a "Gay and Lesbian Issues" group in a long-term psychiatric rehabilitation setting; he reports on the dedicated participation of group members, and on their increased comfort with their own identities and decreased sense of isolation. Hellman (1996) offers guidelines for thorough assessment of consumer sexual identity issues, and of their impact on stress, social supports and psychiatric symptoms. He comments, however, that "whether the inpatient setting reinforces the social isolation and stigma that homosexual individuals commonly experience or allows for their personal healing is left to serendipity unless staff plan and develop a supportive approach that can be applied in a routine and flexibly organized way" (1996, p. 1096).

Coming Out

Sexual minority identity development also involves complex decisions throughout the life span regarding when, how and to whom to disclose personal life information, including sexual orientation or gender identity. Some authors believe that "coming out" to others, or disclosure of GLBT identity, is an important part of the task of developing a positive identity. Some models of gay and lesbian identity development describe common patterns of disclosure and include disclosure as an index of progress in identity development. At first, for example, GLBT individuals may only disclose to other GLBT persons, later to a select number of heterosexual friends and much later to family and/or co-workers.

McCarn and Fassinger (1996) note that disclosure of sexual orientation is significantly determined by environmental factors. Including disclosure behaviors as evidence of identity

development places the full onus of public openness on the individual and ignores the profound impact of hostile environments. Individuals in the armed services, for example, have been strictly informed that to disclose their sexual orientations will risk their jobs; in such circumstances disclosure or nondisclosure is not a legitimate index of integration of sexual minority identity. Similar pressures exist for many ethnic minorities, individuals in isolated rural areas and for individuals in some treatment settings and other controlled environments.

The process of sexual identity development, like other identity development processes, is lengthy and complex and has an impact on all spheres of life. In the past, many years generally elapsed between first awareness of same-sex attractions, first same-sex relationships, disclosure to family and friends, and acquisition of a positive gay or lesbian identity. For example, a 1977 study found that this trajectory typically required 16 years (APA, 1977). More recent studies, however, show a much shorter time period from same-sex awareness (during childhood) to sexual identity consolidation during adolescence (Ryan, in press). This period of coping with difficult, socially stigmatized feelings usually includes adolescence and often leaves GLBT youth alone to negotiate arduous developmental and social tasks.

Implications for Mental Health Care

- Awareness that a positive gay/lesbian identity is associated with improved mental health may help providers offer more effective services to GLBT consumers in a variety of treatment settings.

- Awareness of the phases of sexual minority identity development can help providers better understand the full range of stage-specific behaviors that may otherwise be confusing to consumers and providers alike.

- Mental health providers working with GLBT clients can play an important role in engaging clients in a full exploration of and preparation for disclosure of their minority identity to others. Consumers may need support facing the possibility of job loss, loss of friends and rejection by family members. Identity models suggest that it is most common, and may be most helpful, to move through a progression of disclosure from least to most threatening situations.

- Agencies can communicate openly to GLBT clients that the treatment environment is a safe and confidential atmosphere where neither consumers nor providers will experience or permit discrimination. This can be done by developing appropriate programs and services for these populations, establishing more inclusive questions concerning partnership status, placing targeted pamphlets or posters in public spaces and by including program information relevant to sexual minorities in general agency brochures.

Special Concerns of GLBT Youth

GLBT youth are more likely to attempt suicide than their heterosexual peers, more likely to be victims of violence and are disproportionately represented among homeless and runaway youth.

Special attention must be drawn to the health and mental health needs of GLBT youth. The process of gay or lesbian identity development may begin with a feeling in early childhood of being "different," and may become an increasingly significant concern for adolescents. Adults presenting for gender identity concerns also typically report early childhood onset of their gender dysphoria. GLBT youth face complex developmental tasks in an atmosphere that often includes isolation, hostility, prejudice and potential danger (Ryan & Futterman, 1998; Savin-Williams, 1994). These children are often the targets of peer harassment. Use of the word "faggot," for example, is the most generally accepted put-down among children at any age group across the country and is used to legitimize violence. The adults targeted children might otherwise turn to for support frequently hold the same homophobic attitudes as the peers who threaten them. This combination of circumstances places GLBT youth at particularly high risk for school problems, substance abuse, victimization by family and peers, engagement in high risk behaviors and suicide (Savin-Williams, 1994). GLBT youth are more likely to attempt suicide than their heterosexual peers, more likely to be victims of violence and are disproportionately represented among homeless and runaway youth. Transgender youth may be at particular risk since young people who begin to outwardly express their transgender identity are often ejected from their homes, and may be victimized by both family members and service providers.

While the unique stressors and risk factors for GLBT youth are mostly the same as for adults of this population, their age and dependence on others render them especially vulnerable to the harmful effects of prejudice and of internalized self-hate. Nonetheless the majority of GLBT youth will successfully navigate this arduous journey through stigma and isolation and become well-adjusted adults. Mental health providers should, however, be aware of the extra stressors and unique circumstances facing those GLBT youth who do come to their attention. Each of the subsequent sections of this report will address the concerns of GLBT youth, but an overarching principle must be noted: any youth and family service agency concerned with prevention and amelioration of risk behaviors among youth should develop the capacity to provide appropriate services and outreach to GLBT youth.

Implications for Mental Health Care

- GLBT youth are often ridiculed and rejected by the adults to whom they might turn for help. They cannot assume support is available in mental health service agencies unless information is openly posted or distributed in health and mental health settings indicating that confidential and non-judgmental services are available and how to find them.

- Youth in families with significant presenting problems, such as domestic violence or substance abuse, are already at risk for mental health problems; the complicating factor of sexual or gender identity concerns significantly increases that risk. Ryan and Futterman (1998) recommend assessing all such youth for access to social supports, stage in the coming out process and adjustment. It is also important to assess for substance use behaviors, symptoms of depression and suicidal ideation.

- The Washington Safe Schools Project (Reis, 1997) recommends several steps for making schools (and other public settings) safer for all youth, including:
  - search for, hire and retain a diverse staff,
  - model and require respect and consideration for everyone, and
  - intervene in harassment.

Prevalence and Effects of Violence Against Sexual Minorities

One study estimates that 40 percent of gays have been victims of violence because of their sexual orientation and that family members were responsible for this violence in 49 percent of the cases.

Rates and Nature of Violence

The prevalence and social acceptance of prejudice and violence against sexual minorities impose unique stressors on their mental health and well being. Indeed, the two most commonly noted unique mental health concerns of this population—suicidality and substance abuse—are likely to be significantly fostered by stigma and prejudice. Studies indicate that alarming numbers of gay men and lesbian women have been subjected to harassment and/or violence because of their sexual orientation. One study estimates that 40 percent of gays have been victims of violence because of their sexual orientation and that family members were responsible for this violence in 49 percent of the cases (Martin & Hetrick, 1988, cited in Clermont & Sioui-Durand, 1997). A study of primarily male African-American and Latino gay or bisexual youths found that 40 percent had experienced violent physical attacks from adults or peers and that 61 percent of these attacks had occurred within the family (Hunter, 1990, cited in Savin-Williams, 1994). Youth, young adult and ethnic minority lesbians and gays may be at highest risk for victimization (Ryan & Futterman, 1998).

A 1997 report from the Massachusetts Department of Public Health (MDPH) on *Health Concerns of the Gay Lesbian, Bisexual, and Transgender Community* (The Medical Foundation, 1997) cites data from local and national tracking programs documenting that 1,463 violent incidents targeted against lesbians and gays were reported in the United States in 1994. Of these, 632 were assaults that involved thrown objects, physical or sexual assault, or murder. The Safe Schools Project in Washington state has documented 91 incidents of harassment in K-12 schools over a four year period directed against persons perceived to be gay, lesbian, bisexual or transgender (Reis, 1997). These included 8 gang rapes, 19 physical assaults and 14 incidents of physical or sexual harassment. In 1992, according to FBI hate crimes statistics, 62 percent of victims of anti-gay assault incidents were injured, 35 percent required outpatient care or hospitalization and 3 percent were killed (The Medical Foundation, 1997).

The nature of the violence against GLBT persons highlights the intensity of the prejudice against them. According to the 1992 hate crimes report, anti-gay/lesbian violence, when compared with other hate crimes, is more frequently directed against persons, rather than property, and more frequently involves injury to the victims (The Medical Foundation, 1997). D. Marcel of the Transgender Education Network (TEN) indicates that hate crimes against transgender persons tend to be even more severe and lead to murder more often than those directed against lesbians

and gays. Attacks on sexual minorities usually involve multiple assailants targeting an individual victim (The Medical Foundation, 1997; Reis, 1997), and attackers are often young males (The Medical Foundation, 1997; Fassinger, 1991). "In some of these incidents, students were ... spit at or something was thrown at them. In some cases, students' clothes were pulled up or down or off. One ... led to a teen attempting suicide and requiring mental health hospitalization." (Reis, 1997, p.1)

The Washington state Safe Schools Report arrived at the conclusion that "everyone is vulnerable," noting that the only clear determinant of risk for anti-gay violence was the offenders' *perception* of the sexual orientation of the target. Age, race, sex and *actual* sexual orientation of targets were not determining factors. Results from a 1995 Seattle Teen Health Risk Survey of more than 8,000 students found that not only did 34 percent of lesbian or gay students report having been harassed or attacked at school, but 6 percent of heterosexual students also reported harassment due to being perceived as lesbian or gay. These targeted heterosexuals also suffered many of the same after-effects as gay and lesbian youth. (Reiss, 1997)

Effects of Victimization

Researchers have found that the effects of anti-gay/lesbian victimization on children or adults may include lowered self-esteem, shame, guilt, depression, post-traumatic stress, running away and homelessness, school related problems, conflict with the law, substance abuse, prostitution and suicide (Reis, 1997; Ryan & Futterman, 1998; Savin-Williams, 1994; Shannon & Woods, 1991). In one study, two-thirds of gay and bisexual male youths reported abuse at school; of these, 40 percent had problems with truancy, and 28 percent dropped out (Remafedi, 1987, cited in Savin-Williams, 1994). Nearly half of these same youths had run away at least once. The Seattle study also found that gay, lesbian or bisexual youth, as well as heterosexual students who had experienced anti-gay harassment, missed whole days of school out of fear for their safety (Reis, 1997).

Ryan and Futterman (1998) note that ongoing harassment and rejection, coupled with inadequate family support, can lead to running away from home. Studies suggest that as many as one in four street youth may be gay or lesbian, with proportions as high as 30 percent to 40 percent in some cities (Ryan & Futterman, 1998). Many of these youth may have been forcibly ejected by their families and may often have encountered barriers to effective social service support also due to harassment and prejudice. Savin-Williams (1994) notes that homeless and runaway youth are at high risk for becoming involved in illegal activities to survive on the streets, including drug use and prostitution, placing them at extreme risk for HIV infection.

The Safe Schools Project found that substance abuse and suicide attempts were also common reactions to harassment. Six youths in this study who were victims of harassment reported that they had begun or increased substance use following harassment, seven reported suicide attempts and one mother reported that her son had committed suicide. (Reis, 1997)

Fear of Reporting Harassment

Rates of harassment and violence against sexual minorities are probably grossly underreported because victims usually do not seek help following attacks due to fear of exposure and/or further victimization by caregivers. One study found that 67 percent of victims who had not reported their attacks stated they perceived police as homophobic, and 14 percent feared police abuse. That study found that nearly one in five gays or lesbians had experienced verbal or physical abuse from police (The Medical Foundation, 1997). A 1992 study of gays and lesbians on college campuses found that faculty, staff and administrators had perpetrated 23 percent of the verbal or physical abuse the students had experienced (D'Augelli, 1992, cited in Savin-Williams, 1994). One fourth of the incidents reported to the Safe Schools project were witnessed by an adult; approximately half of the time the adult did nothing to intervene (Reis, 1997).

Implications for Mental Health Care

- Mental health providers must recognize the pervasiveness of GLBT victimization. Providers can help consumers acknowledge the problem and work through intense feelings resulting from victimization. They can also assist consumers in identifying legal, medical and other resources that may be helpful. (Shannon and Woods, 1991)

- Demographics of assailants suggest that training programs directed at heterosexual male adolescents to promote tolerance, respect and nonviolent conflict resolution may reduce the incidence of violence against GLBT persons.

- Schools (and other public agencies) can take steps to actively reduce the victimization of all youth, including:
  - intervene in harassment;
  - establish and publicize methods for reporting GLBT harassment and take reports seriously;
  - address the needs of the targeted person for safety and support and address the needs of witnesses and the rest of the community.
  (Reis, 1997)

- Vigorously prosecute anti-gay violence to send a message of concern for the safety of GLBT persons and of intolerance of perpetrators. (The Medical Foundation, 1997)

Substance Abuse

Treatment settings that do not provide a safe atmosphere in which individuals can address internal conflict with their sexual orientation or gender identity may not effectively address a significant underlying cause of substance abusing behaviors.

Rates

Many writers note that drug and alcohol abuse are significant physical and mental health concerns for sexual minorities. One study, with a sample of 3,400 lesbians and gay men, found that lesbians and gays were twice as likely to be moderate drinkers and reported rates of alcohol problems twice as high as heterosexuals, but were about equally as likely as heterosexuals to be heavy drinkers (McKirnan & Peterson, 1989, cited in Ryan & Futterman, 1998). The National Lesbian Health Care Survey, with a sample of just under 2,000 women, found that 25 percent of respondents drank alcohol more than once per week, 6 percent daily and 14 percent worried about their use of alcohol (Bradford, Ryan & Rothblum, 1994). Although little empirical research has been conducted, rates of substance abuse are thought to be disproportionately high among the transgender population (Transgender Education Network, 1998). Tobacco use also appears to be considerably higher among sexual minority persons than in the population at large (The Medical Foundation, 1997).

Contributing Factors and Related Concerns

Many authors note the likelihood of a link between internalized homophobia, ongoing discrimination, low self-esteem and increased use of alcohol and drugs (Browning et al., 1991; Clermont & Sioui-Durand, 1997; The Medical Foundation, 1997). Browning, Reynolds and Dworkin (1991) comment that "using drugs/alcohol may be an attempt [by a lesbian woman] to numb herself to her emotions and to avoid accepting herself as a lesbian" (p. 189). This idea is supported by a 1988 study of 20 gay male recovering alcoholics who all reported that drinking relieved their sense of guilt and made it possible for them to enjoy sexual activity; however, all participants also reported that they had been unable to consciously accept their sexual orientation until they stopped using alcohol to cope with it (Kus, 1988, cited in The Medical Foundation, 1997). The same concerns regarding social stigma, self-acceptance and shame are likely to play a role in substance use among transgendered persons. "Dealing with substance abuse is a major therapeutic issue in this client population. Because of the pervasive shame and guilt around their feelings and behaviors, alcohol and other drugs become a convenient and accessible means to dull the pain the transgendered feel much of the time" (Anderson, 1998, p. 220).

For many years, and still in some locations, the only venue for socializing, privacy and openness for GLBT persons was gay or lesbian bars. The reliance on bars as GLBT gathering places may

have increased the tendency to integrate alcohol and other substances into their social lives, thus contributing to substance abuse among this population (Browning, et al., 1991; Clermont & Sioui-Durand, 1997; Savin-Williams, 1994; Shannon & Woods, 1991). However, the frequent emphasis on the role of bars in increasing substance use among this population may downplay the significance of discrimination and homophobia as contributing factors in substance use and abuse (The Medical Foundation, 1997).

An important health and mental health concern related to substance abuse is the increase in risk behaviors associated with substance abuse. Rates of violence, suicide and unsafe sexual behaviors are all higher under the influence of drugs or alcohol.

Issues in Service Settings

Questions have been raised about the course of substance abuse recovery for GLBT clients in service settings that may not be sensitive to their needs. Browning et al. (1991) note that lesbians in treatment settings must grapple with whether to come out to staff, whether it will be safe to involve their partners in their recovery, and with homophobic or sexist remarks from other group members. Shame, guilt and denial are potent elements both in coming to terms with sexual identity and in the cycle of substance abuse relapse. Treatment settings that do not provide a safe atmosphere in which individuals can address internal conflict with their sexual orientation or gender identity may not effectively address a significant underlying cause of substance abusing behaviors (The Medical Foundation, 1997).

A recent needs assessment in Massachusetts explored barriers encountered by transgender consumers in substance abuse treatment, many of which are likely to exist in other residential and outpatient settings as well (TEN, 1998). Interviews with staff at 21 treatment sites revealed that at least 111 identified transgender or transsexual consumers had been served in the past 10 years, and yielded important information regarding the need for appropriate service delivery. Barriers to effective treatment included:

- lack of staff training, awareness or acceptance of transgender concerns;
- difficulties coordinating appropriate sleeping arrangements, or appropriate assignment to single sex treatment programs, for transgender consumers;
- absence of targeted support groups or services for these consumers;
- lack of attention in treatment to their gender identity concerns;
- staff confusion regarding differences between sexual orientation and gender identity; and
- problems with violation of privacy around urine screenings.

The Substance Abuse section of the MDPH report concludes that "the major impediments to effectively responding to GLBT substance abuse are the general unavailability of services specifically targeting the GLBT community, and in [*sic*] the lack of sensitivity and openness regarding lesbian and gay issues among traditional alcohol and drug treatment programs" (The Medical Foundation, 1997, p. 42). The report also notes that efforts at outreach and prevention may help reduce rates of substance abuse in the GLBT population.

A positive element in the treatment of gays and lesbians with substance abuse problems is the widespread availability in urban areas of gay/lesbian Alcoholics Anonymous and Narcotics Anonymous meetings. "One aspect considered most beneficial of the gay Alcoholics Anonymous setting is the opportunity for gay men and lesbians to feel a part of a community of recovering lesbian and gay alcoholics, and to explore the personal and social consequences of sexual orientation in a sensitive environment" (The Medical Foundation, 1997, p. 41). Experts caution, however, that treatment or self-help settings that are lesbian or gay affirmative are not necessarily transgender affirmative.

Implications for Mental Health Care

- Providers working with gay individuals or couples should have a solid foundation in chemical dependency assessment and treatment (Shannon & Woods, 1991).
- Providers and agencies who are knowledgeable about gay, lesbian, bisexual and transgender community resources that address addiction and recovery will be better able to assist their clients.
- A substance abuse history should be a regular part of intake with these clients and therapists need to be aware of the use of substances to self-medicate for depression (Bradford et al., 1994).
- Treatment staff should be trained to understand and adequately serve transgender consumers.

Suicide

A 1995 study conducted by the Massachusetts Department of Education found that lesbian, gay or bisexual students and those who had had same-sex experiences were four times more likely to have attempted suicide than heterosexual students.

Rates

Much has been written on this subject since the U.S. Department of Health and Human Services released its 1989 *Report of the Secretary's Task Force on Youth Suicide*. The report stated that gay and lesbian youth are two to three times more likely to attempt suicide than their heterosexual counterparts and that they may comprise up to 30 percent of completed youth suicides (Gibson, 1989). The statistical conclusions Gibson drew from his review of existing research have been questioned, but numerous experts agree that gay and lesbian youth appear to be at considerably higher risk for suicidal ideation and behavior than their peers. Ethnic-minority gays and lesbians may be at higher risk for suicide attempts than white gays and lesbians. Clinical reports and anecdotal information on transsexuals suggest that suicidal ideation and attempts are high in this population as well (Anderson, 1998; Brown & Rounsley, 1996).

Attempts to estimate rates of suicidality among GLBT persons are largely dependent on data gathered from individuals who are open about their sexual orientation or gender identity, and they do not represent all GLBT persons. Thus it is difficult to determine representative figures. A 1995 study conducted by the Massachusetts Department of Education found that lesbian, gay or bisexual students and those who had had same-sex experiences were four times more likely to have attempted suicide than heterosexual students (cited in Ryan & Futterman, 1998). The National Lesbian Healthcare Survey found that 18 percent of respondents reported having attempted suicide and that rates were highest among lesbian youth, 25 percent of whom had attempted suicide. Although the proportion of lesbians of color in this study was small (about 12%), African-American (27%) and Latina (28%) women who had attempted suicide reported higher rates of attempts than did white women (16%) (Bradford et al., 1994). A study based on an ethnically diverse sample of gay and bisexual male youth, ages 14-19, found that 39 percent had attempted suicide, an additional 37 percent had thought about suicide daily for at least a week and 60 percent reported suicidal thoughts in the week before data collection (Rotheram-Bourus, et al., 1992, cited in Savin-Williams, 1994). Rates of suicide attempts appear to be highest among victims of sexual abuse or violence and homeless or runaway youth (Ryan & Futterman, 1998).

The Seattle Teen Health Risk Survey found that 1 in 5 gay, lesbian or bisexual high school students had made a suicide attempt within the previous year, and 1 in 10 had made an attempt

serious enough to require medical attention (Reis, 1997). Similar rates of suicidal behaviors were reported by heterosexual youth who had been targets of anti-gay harassment, but rates were much lower for heterosexual youth who had *not* experienced anti-gay harassment. This and other findings suggest a direct relationship between discrimination and self-destructive behaviors. "At whatever age a person begins to associate a Gay, Lesbian or Bisexual label with him or herself, all the years of overheard, if not personally-directed, slurs may become linked to the young person's core identity. The learned message 'Gays are bad people' may metamorphose into 'I am a bad person' and self-destructive behavior may ensue" (Reis, 1997, p. 26).

Risk Factors

Several notable factors appear to be associated with higher likelihood for attempting suicide. Summarizing some of these, Ryan and Futterman (1998) comment: "Studies of gay and bisexual attempters show that they were more likely to have self-identified as gay or bisexual and come out to others at younger ages, to have friends and relatives who attempted or committed suicide, and to have been rejected because of their sexual orientation....Nearly half of gay and bisexual youth in one study reported family problems as the precipitating event. One out of three suicide attempts was related to conflict over sexual identity. Three out of four attempts followed self labeling as gay or bisexual" (p. 61). Savin-Williams (1994) reports findings that suicide attempts were most likely to occur during questioning of sexual identity or following same-sex sexual activity.

Although clinical depression is strongly associated with suicidal thinking and behavior, the relationship between depression and suicidality in this population is unclear. Suicidal thinking and behavior among sexual minorities may be more related to persecution than to clinical depression. More than a third of respondents to the National Lesbian Health Care Survey reported "a long period of depression or sadness," and 73 percent of all respondents had sought mental health care at some time (Bradford et al., 1994). The most common reason for seeking help was feelings of sadness or depression. The researchers considered wide use of mental health services as a measure of resiliency and a positive coping behavior in managing a stigmatized identity. Alcohol use, which as noted may be higher in the lesbian and gay community, is also associated both with risk for suicide (McGrath et al., 1990) and with depression. Yet an intriguing longitudinal study of multiple pairs of twins found no increased risk for depression but a substantial risk and greater lifetime prevalence of suicidal behavior for the same-sex oriented twins in the pairs (Herrell, 1996, cited in Ryan & Futterman, 1998). Ryan & Futterman (1998) note that this study "offers compelling evidence that stressors related to being gay increase risk for suicidal behavior" (p. 62).

Hellman (1996) suggests that an "interactive effect" may occur between mental illness and developmental vulnerabilities that could increase the risk of suicide among sexual minority persons with psychiatric concerns. He notes that the highest risk period for suicide among people

with schizophrenia is during the first four years following diagnosis and that this often coincides with the period of consolidation of sexual identity (i.e. late adolescence).

Little empirical work has been done on rates of suicide or depression among transgendered persons. Brown (Brown & Rounsley, 1996) estimates that 17 percent to 20 percent of her transsexual clients have attempted suicide. Ryan & Futterman (1998) note that youth who do not conform to gender stereotypes are the most frequently abused of sexual minority youth, and report that cross-gender youth and youth who have used drugs are at substantially higher risk for suicide than their other sexual minority peers.

Implications for Mental Health Care

- GLBT youth may be at increased risk of self-destructive behavior without a supportive and nonjudgmental environment in which to explore their feelings.
- Providers should consider the relevance of sexual orientation or gender identity issues in assessing consumers who are admitted to treatment for suicidal thinking or behavior (Hellman, 1996).
- Providers may find it useful to explore the history and resolution of suicidal thoughts or behaviors among adult sexual minority consumers.
- Youth facing mental and behavioral health stressors such as substance abuse, sexual abuse, violence, suicide or other loss among family or friends may be at higher risk for self-harm if they are also coping with questions about sexual orientation or gender identity.
- Special attention should be paid to the safety needs of youth addressing questions of sexual identity early in adolescence or youth whose family or school environments are openly rejecting and hostile.

Transgender Concerns

Brown states that 85 percent of her patients recognized their gender dysphoria before grade school. She describes these clients as living with a burden of chronic emotional pain, which they are afraid to discuss for fear of being labeled "crazy."

A dramatic recent lawsuit involving the Fire Department of Washington, D.C., illustrates both the ignorance and prejudice facing transgender persons, and the dangers and costs of inadequate training of service personnel dealing with this stigmatized minority. Rescue workers at the scene of a serious auto accident administering emergency care to a victim dressed in women's clothing ceased providing medical care when they discovered the victim had male genitals. Witnesses reported that the medical personnel shouted insults and jokes at the victim and that medical intervention was not resumed until five to seven minutes later when a supervisor arrived and took over. The victim later died at the hospital. The victim's mother filed a wrongful death suit and was awarded nearly $3 million in damages. (Chibbaro, 1998a&b)

This incident starkly illustrates the need for adequate training of social services and health personnel to address the needs of this minority. Health and mental health providers should be educated to combat stereotypes, misunderstanding, hatred and failure to deliver compassionate services to all persons. Further definition of terms and a brief overview of issues relevant to sensitive and appropriate mental health service delivery are offered below.

Terminology and Prevalence

In defining basic terms earlier in this report, we distinguished between sexual orientation and gender identity. This section of the report primarily addresses the needs of persons with gender identity concerns. There are many different experiences and expressions of transgendered identity. Some individuals choose to challenge gender norms but do not question their own assigned gender. Others live with a pervasive sense of a schism between their gendered sense of self and their anatomical sex. Defining two terms more fully will assist in understanding distinctions among sexuality, sexual orientation and gender identity:

- *Cross-dressers* or *transvestites* are usually heterosexual, married, well educated men (Brown & Rounsley, 1996), who receive erotic pleasure and/or a sense of anxiety-reduction from wearing articles of women's clothing (Anderson, 1998). Cross-dressing usually begins in adolescence (Anderson, 1998); and the majority of people who cross-dress do not question their gender identity (Brown & Rounsley, 1996).

- *Transsexual* refers to individuals who have a persistent sense that their felt identity is in opposition to their anatomical sex. Transsexuals may be male or female, heterosexual,

homosexual or bisexual; they typically report gender identity confusion dating from as early as age 3 or 4 and low libido (Anderson, 1998). Transsexuals may also cross-dress, but the behavior usually begins earlier in life than with transvestites, and it represents an attempt by the individual to express to the world their true felt gender identity.

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) changed the diagnostic terminology from *transsexual* to *gender identity disorder* (APA, 1994). Mildred Brown and Chloe Ann Rounsley, in their 1996 book, note that no single trigger or determinant has been found to explain gender identity disorder. They report that a possibility exists that a hormonal imbalance during a critical stage of embryonic development may lead to a distinction between the sex of the genitals and the gender-identity developed in the portion of the brain where gender identification is codified. They also note a study in the Netherlands where posthumous autopsies revealed that the brain structures of male transsexuals were similar in important ways to those of adult women rather than men.

Prevalence statistics are difficult to gather for transgender persons for the same reasons that they are difficult to obtain for gays and lesbians. Also, fear, discrimination and hiding lead many members of this minority to live in relative secrecy. Information from the Harry Benjamin International Gender Dysphoria Association (HBIGDA) indicates that approximately 1 in 11,900 men and 1 in 30,400 women are transsexual (HBIGDA, 1998). The DSM-IV, cites data from Europe indicating that roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment surgery (APA, 1994). Brown and Rounsley (1996) cite these DSM-IV statistics and also report that as of 1988 approximately 6,000-10,000 individuals had undergone sex reassignment surgery in the United States, while many other Americans may have traveled overseas where the surgery is less expensive.

Mental Health Needs

It takes little exposure to the experience and concerns of transgendered persons to gain an awareness of the lifelong persecution and suffering they experience. Brown (Brown & Rounsley, 1996) states that 85 percent of her patients recognized their gender dysphoria before grade school. She describes these clients as living with a burden of chronic emotional pain, which they are afraid to discuss for fear of being labeled "crazy." She also notes that their emotional pain and discomfort with their bodies can become extreme, prompting some to attempt genital self-mutilation or suicide.

Transgender persons may seek therapy for a number of reasons. Some do so following a significant life transition, such as having children reach adulthood or separating from a spouse, that leads them to a willingness to face this life-long concern (Brown & Rounsley, 1996). Some may seek support because of depression, suicidal thoughts or substance abuse. Individuals may also enter therapy to meet requirements to obtain a referral for medical treatments, to find a case manager to help them through a maze of procedures and changes, to get help determining when

and how to tell others, or for post-operative support (Anderson, 1998). Some may enter therapy as a result of pressure from family members to be "cured." These situations can all be used as opportunities to educate everyone involved about gender identity disorder, if the therapist is prepared to do so.

Brown and Rounsley (1996) note that there are some feelings that virtually all transsexuals struggle with: fear of losing family and friends or of ridicule and attack; guilt because they hurt themselves and others either by hiding the truth or by coming out; anger at themselves, God and society; shame because of the stigma they face; and poor self-esteem from hiding their true selves all of their lives. They suggest that calling transgendered persons by the name that corresponds to their self-identified "true self" is an important first step in establishing a respectful and supportive relationship.

Providers may be called upon to help these consumers deal with discrimination and victimization, and with problems accessing appropriate health care. Health insurance companies, for example, will not pay for most gender identity related medical treatments and offer only limited mental health reimbursement.

Role of the Mental Health Service Provider

A therapist working with transgender clients (as with all members of sexual minorities) will be called upon to fulfill multiple roles beyond the traditional roles of psychotherapy. Brown and Rounsley (1996) note that an important role of the therapist working with a transgender client is to depathologize the condition and provide clients with information and referrals relevant to their condition. Anderson (1998) similarly comments that "all the traditional psychological interventions will be wasted without the empowering impact of information about this condition and the many other sufferers who are coping with and resolving gender-identity issues" (p. 226). Group therapy has been recommended with all sexual minorities to combat isolation and provide a safe atmosphere in which to grapple with issues related to sexual orientation or gender identity.

Detailed standards of care from HBIGDA guide treatment by most reputable gender identity disorder specialists and centers. These standards outline the roles of mental health and medical personnel working in concert to treat consumers with gender identity disorders. Clients must first have a full psychological evaluation and must be diagnosed with a gender disorder as specified in either the DSM or the International Classification of Diseases (ICD). Clients who meet the diagnostic criteria can choose to begin a path called "triadic treatment," which involves hormonal treatment, "real life experience" and sex reassignment surgery. Hormone treatment cannot be recommended until *at least* 90 days after initial evaluation. (HBIGDA, 1998)

Although standardized guidelines may help ensure high-quality services and avert pursuit of significant change without full preparation, the HBIGDA standards of care are also controversial. Some transsexuals experience the required steps as "hoops" they must jump through in order to

gain access to services that could relieve life-long suffering, and they may resent the roadblocks and delays (Brown & Rounsley, 1996; Griggs, 1998).

The initial task of the mental health provider, to provide a thorough assessment and diagnosis, is an unusually complex one requiring specific expertise. Accurate diagnosis is particularly important since sex reassignment surgery is dependent upon a diagnosis of gender identity disorder, and many people may attempt to pursue sex reassignment surgery who do not have a gender identity disorder (Brown & Rounsley, 1996). The complexity of the diagnostic task, and the role that the mental health practitioner plays in determining appropriateness of medical referral, lead some experts to underscore the importance of referring transsexual clients to trained transgender specialists (e.g., Anderson, 1998). Others note that the quality of the therapeutic relationship is paramount and that therapists can gain expertise and education in this area while working with transsexual clients (e.g., Griggs, 1998).

Implications for Mental Health Care

- It is particularly important to offer mental health professionals training opportunities in order to work through preconceptions and prejudices that may interfere with their ability to serve this stigmatized population.
- Providers will be better able to serve a variety of sexual minority populations if they thoroughly understand distinctions among sexual orientation, sex role and gender identity.
- Providers can expect that transgendered clients have faced significant prejudice and may experience fear and discomfort discussing their gender identity concerns.
- Agencies and providers should be prepared to assist consumers with gender identity concerns, respectful of their chosen identities and preferred names, and aware of the phases of medical treatment for gender identity disorder.

HIV and AIDS

HIV-positive men with no one to talk to about their illness had higher scores on a measure of depression and reported more HIV-related symptoms.

Although the rates of human immunodeficiency virus (HIV) infection among adult gay men appear to have been declining in the 1990's, male-to-male sexual contact continues to account for the largest proportion of virus transmission among men in the United States (CDC, 1998a). Because of the unique impact the disease has had on the GLBT community, both in terms of numbers of people infected and the loss of peers and partners, counseling concerns related to HIV and Acquired Immune Deficiency Syndrome (AIDS) must be addressed in any overview of GLBT mental health concerns. It is not within the scope of this report to provide in-depth coverage of the complex array of psychosocial needs resulting from the AIDS epidemic, but a brief outline of the primary issues of which all mental health service providers and agencies should be aware is offered below.

Prevalence

The AIDS epidemic disproportionately affects a variety of populations already stigmatized or underserved within the United States: men who have sex with men, injection drug users, African Americans, Latinos, women and youth. According to the Centers for Disease Control (1998b), men who have sex with men comprised 60 percent of the men diagnosed with AIDS in 1997, and injection drug users accounted for 24 percent of men and 47 percent of women diagnosed with AIDS in that year. Although African Americans represent only an estimated 13 percent of the U.S. population, they accounted for 45 percent of reported AIDS cases in 1997 (CDC, 1998c). Similarly, Latin Americans/ Hispanics, who account for approximately 10 percent of the U.S. population, accounted for 21 percent of AIDS cases reported in 1997 (CDC, 1998e). AIDS is now the leading cause of death among African American women ages 25-44 (CDC, 1998f). Yet due to advances in medical treatment and public education, the incidence of AIDS cases and of death from AIDS declined significantly in 1997 among men who have sex with men, male and female injection drug users and all racial/ethnic populations (CDC, 1998a).

Many experts point out the special risks for HIV infection among youth, noting that although the disease may not manifest until adulthood, it is likely that many people are infected in adolescence or young adulthood (Hoffman, 1991). Between July 1997 and June 1998, youth between the ages of 13 and 24 accounted for 4 percent of AIDS cases but 15 percent of HIV infection without full-blown AIDS (CDC, 1998b). Among young men (ages 15-22) in urban counties who have sex with men, 8 percent to 14 percent of African Americans were found to

be infected with HIV, 2 percent to 11 percent of Hispanics and 2 percent to 6 percent of whites (CDC, 1998a).

Stigma

Although the situation has improved since the early years of the AIDS epidemic—when infected individuals were denied medical services, ejected from their religious communities and abandoned by neighbors and family members (Kubler-Ross, 1987)—a strong stigma still surrounds HIV and AIDS that seems to be multiply-determined by misinformation, fear of contagion and the stigma associated with homosexual activity, substance abuse, chronic illness and death (Hoffman, 1991; Kubler-Ross, 1987; Tross & Hirsch, 1988). A CDC report on HIV prevention among men who have sex with men notes that homophobia is one of the important cultural barriers that must be overcome to promote prevention efforts.

I. Michael Schuff (1997) cites research indicating a correlation between AIDS-phobia and homophobia among rural service providers. He adds the stigma surrounding mental health care to the list of stigma that interfere with appropriate HIV service delivery, noting that many persons, including physicians, in rural or small town settings may see HIV infection as a purely physical problem and postpone or avoid referral for counseling and support. Ball (1994) notes that the HIV epidemic may intensify the isolation already experienced by sexual minority persons with mental illness; he writes that members of his gay and lesbian issues group were unable to comfortably discuss their fear, concerns and losses related to HIV until many months into group therapy.

It is important to distinguish between behaviors and populations; not all men who have sex with men, for example, identify themselves as gay or bisexual. There are no risk *groups* for HIV transmission; there are only high-risk *behaviors*. The focus on identifying groups at risk not only unnecessarily stigmatizes large numbers of people but also conceals the nature of HIV risk from many people who may be engaging in high-risk behaviors.

Mental Health and Counseling Concerns Related to HIV and AIDS

Prevention, Education and Testing

Until there is a cure for HIV, the only interventions that can save lives are prevention and education. HIV education, risk assessment, counseling and testing can be readily incorporated into routine mental health consumer care. Ryan and Futterman (1998) provide excellent guidelines for doing so. They note that HIV counseling and testing provide an opportunity to identify individuals who are HIV positive and to begin appropriate medical services for them; to relieve the anxiety of HIV negative persons; to engage in open dialog regarding sexual health, behaviors and orientation; and to provide HIV education, risk-reduction planning and skills

training. These opportunities are important for all consumers, but they are particularly critical for adolescents. Experience has shown that HIV education programs must also be culturally competent to be successful; persons of differing cultural backgrounds have widely varying terms, understandings and privacy needs related to discussing or changing sexual behaviors.

Progression of the illness

Many experts note the stressful impact of the slow and progressively debilitating nature of HIV infection and maintain that the counseling and mental health needs of infected individuals, and of their significant others, change substantially during the course of the illness (Eversole, 1997; Hoffman, 1991; Ryan & Futterman, 1998; Schaffner, 1990). The HIV virus destroys human health by slowly eroding the functioning of the immune system; thus people with AIDS who die do so from the effects of opportunistic infections rather than from the virus directly. Due to the protracted nature of the illness, HIV-infected persons and their caregivers often suffer from chronic stress associated with health status, access to and affordability of health care, disclosure and exposure, employment policies and availability of emotional supports (Schaffner, 1990). Differing phases in the course of the illness can be conceptualized as outlined in the box on page 41.

Important new medical treatments, involving combination drug therapies, have significantly changed the course of the illness and have lengthened the lives and improved the quality of life of persons infected with HIV. The duration of the phases outlined in the box below may be considerably longer than would have been the case even a few years ago; many people with HIV are living full lives for many years with proper medical and behavioral care following diagnosis.

Tross and Hirsch (1988) note that a significant proportion of people with AIDS will also be affected by global cognitive deterioration caused by direct brain infection with HIV—known as AIDS Dementia Complex (ADC). They comment that mental health providers should be vigilant for changes in mood, speech, motor control or pain in HIV-infected clients that may indicate the need for medical, neurological or psychiatric evaluation.

Phases in the Progression of HIV Disease, and Related Mental Health Concerns

Immediately following diagnosis —

Individuals may display extreme shock, anger, anxiety, fear, and/or dread following an initial positive diagnosis of HIV infection. At the same time that they are having an emotionally overwhelming experience, they need to begin planning immediate changes in lifestyle—including a course of medical referrals (Hoffman,1991).

Asymptomatic phase of HIV disease —

Asymptomatic infected individuals may feel well physically but be anxious or depressed (Schaffner, 1997). In this phase important psychological work of coping with the illness takes place, including practicing and establishing changes in risk-related behaviors, pursuing and cooperating with medical treatments, and addressing pre-existing or existential mental health concerns and questions (Eversole, 1997).

Becoming symptomatic —

A second crisis, like the one following initial diagnosis, commonly ensues in response to the development of immunodeficiency symptoms. Tross and Hirsch (1988) indicate that newly symptomatic individuals show significant distress, including depression, anxiety, mental avoidance, and hostility. Yet, Schaffner (1997) notes, they may be ambivalent about pursuing therapy that is not directly related to relief of their physical symptoms.

Diagnosis with AIDS —

A third crisis follows the diagnosis of full-blown AIDS. Clients may experience a complicated mix of urgent and intrusive medical needs, accompanied by a need to address issues of death and dying and to resolve life concerns and spiritual questions. Dworkin and Pincu (1993) cite research in which people with AIDS ranked existential issues first among their most pressing concerns and health concerns last.

Common Counseling Concerns

Clients with HIV express a number of common concerns, many of which are challenging to providers. These may include concerns about how and to whom to disclose HIV status; guilt and/or rage related to method of acquisition of the disease; unresolved and medically crucial substance abuse behaviors; critical needs for social support; grief over the loss of health and opportunity and at the impending loss of life; impact on feelings about sexuality and sexual orientation; and preparation for death and dying (Eversole, 1997; Hoffman, 1991; Schaffner, 1990). Providers need to know, for example, the legal and ethical guidelines of their states and professional organizations regarding notifying third parties of a consumer's HIV status. Eversole (1997) comments that effective practitioners must be able to talk freely about sex, must be able to teach safer sex techniques and the skills for negotiating these techniques, and must be

comfortable taking a thorough sexual history with all clients in order to make accurate HIV risk assessments.

Assessing the support systems of persons with HIV is important since social supports may affect health, adjustment and longevity. Hoffman (1991) cites research indicating that HIV positive men with no one to talk to about their illness had higher scores on a measure of depression and reported more HIV-related symptoms. She notes that the support networks of gay men have been shown to consist predominantly of other gay men (Hoffman 1991); these networks may shrink as peers become ill or die (Tross & Hirsch, 1988).

Providers must also be comfortable addressing existential concerns related to life meaning, dying and death. Schaffner (1990, p. 13) notes: " In our culture, it has been taboo to talk about death, yet the HIV patient desperately needs to do so—to share his [*sic*] feelings about his [*sic*] death, to have them respected, and to be comforted." Eversole (1997) comments that effective HIV/AIDS practitioners must also be clear about their own spiritual beliefs and able to address the spiritual concerns of clients.

Care of Providers

The chronic stress, existential crises, debilitation and loss associated with HIV and AIDS have an impact on infected persons and their caregivers, including medical and mental health professionals. Eversole (1997) notes that HIV and AIDS create more need than any one person can fulfill and that providers and agencies need to have strategies in place to avoid the tendency toward burnout among AIDS-related counselors and support services staff. Schaffner (1990) comments that providing services to the HIV-infected person can be "emotionally exhausting" and can require of providers great dedication, compassion, and tolerance of suffering and loss. Experts advise working in teams, collaborating with multiple professionals, limiting the number of HIV-infected clients per practitioner and increasing supervision to help providers avoid burnout.

Special HIV Concerns of Sexual Minorities

AIDS-Related Bereavement

The prevalence of HIV/AIDS among men who have sex with men has led to the experience of widespread loss and multiple bereavements, which affect the stress, coping and identity development processes of both gay men and lesbians. Ryan and Futterman (1998) point out that adolescents and young adults newly coming out enter a community where chronic illness and premature death are commonplace.

A longitudinal study of more than 1,000 gay men in New York City found that 73 percent had experienced at least one major loss due to AIDS. Often the bereaved were also HIV infected.

Bereaved gay men, in comparison to non-bereaved gay men, were more depressed; more vulnerable to substance abuse; considered suicide more frequently; and were more likely to seek medical, psychological and spiritual help. These researchers found that people who lacked emotional and social support while caring for a person with AIDS suffered more intense and prolonged grief following that person's death than did caregivers with reliable support. (Dean, 1995)

HIV-Negative Gay Men

HIV-negative gay men may find it hard to discuss their health status and may fear hurting the feelings of HIV-positive friends to such a degree that some lie about being negative (Shidlo, 1997). They may have extreme anxiety about how to stay HIV negative and fear that infection is inevitable; those who have suffered the loss of loved ones may experience "survivor guilt" (Moskowitz, 1989). Shidlo (1997) maintains that developing a positive identity around being HIV-negative is crucial to fostering active commitments to ongoing health among these men. He also suggests that it is important to offer HIV-negative men venues for openly expressing their feelings "without fear of neglecting, offending, or hurting" their HIV-positive peers (p. 179).

Implications for Mental Health Care

- Mental health agency staff should be competent to do HIV risk assessments and should be aware of appropriate testing and counseling services. Ryan and Futterman (1998) provide in their book step-by-step guidelines for HIV assessment, pre- and post-test counseling and intervention. The AIDS Mental Health Training Program at the University of California offers HIV training tailored to providers and educators who work with people with serious mental illness. (See resource section.)

- Mental health agency staff should be sensitive to the difference between identifying risky behaviors vs. erroneously labeled "risk groups." Comprehensive intake procedures should include a history of risk behaviors, regardless of how consumers label their identities.

- Provider networks should be established across disciplines and agencies to ensure coordinated care of this complex biopsychosocial problem.

- Education, case management and counseling are critical HIV-related services, from initial pursuit of testing through the course of the illness.

- Ball (1994) encourages the development of gay and lesbian support groups in psychiatric settings and recommends that group leaders encourage open dialog about issues related to HIV as the group becomes ready.

- Providers need to be aware of changing needs of consumers and their caregivers across the phases of the illness.

- Support groups combat stress and isolation that affect both HIV infected persons and their caregivers and communities. Specific groups have been helpful for people with HIV, people with AIDS, caregivers, survivors, HIV-negative gay men and providers working with HIV-affected consumers.

Summary

Gay, lesbian, bisexual or transgender persons are represented in all ethnic and racial groups, geographic areas and socioeconomic strata, yet the invisible nature of their minority status may conceal the true size of this population, increase the individual impact of discrimination and inhibit the development of appropriate mental health and social services. Heterosexism and homophobia in American society and in treatment settings add to social pressures that contribute to mental health concerns, including higher rates of suicide, possibly elevated rates of substance use and vulnerability to hate-based verbal and physical attacks.

State Mental Health Agency (SMHA) officials and mental health providers should be aware of the societal pressures facing persons with sexual orientation or gender identity concerns, and should understand the process of sexual identity development for gays, lesbians and bisexuals and gender identity issues and related medical care concerns for transgendered persons. SMHAs also need to provide particular support to GLBT youth through outreach, education and interventions designed to reduce high risk behaviors, homelessness and victimization by others. Similarly, comprehensive mental and behavioral health care should be developed to respond to the needs created by the HIV epidemic and to sensitively address the special impact of the illness on those it affects disproportionately—including men who have sex with men, injection drug users, African Americans and Latin Americans/Hispanics.

Some innovative programs have been designed to counter inequity and appropriately respond to the mental health needs of gay, lesbian, bisexual and transgendered consumers. The following section profiles examples of culturally competent programs serving GLBT persons. Also, a unique statewide effort sponsored by the Massachusetts Department of Public Health to research and remedy barriers to accessing health and mental health services for GLBT consumers yielded a set of "Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients." These standards can provide important guidance to SMHAs regarding the development and implementation of appropriate policies and services. (See GLBT Health Access in the resources section for more information.)

Model Program:
Seattle Counseling Service for Sexual Minorities

This was the first mental health agency in the United States to specifically serve the unique needs of the gay, lesbian, bisexual and transgender communities.

Overview

Program History

Seattle Counseling Service for Sexual Minorities (SCS) began as a helpline and drop-in support center in 1969 after the founder had been working with street youth for a number of years. He noticed that many of the kids who were "on the street" were identifying as gay, lesbian or transgender. After applying for grant money, he established the agency, with support entirely from volunteers who were enrolled in graduate counseling and social work programs in the area. This was the first mental health agency in the United States to specifically serve the unique needs of the gay, lesbian, bisexual and transgender communities.

In 1975, King County (Wa.) Mental Health Division granted SCS its first license to provide services as a recognized community mental health agency. United Way followed suit in the early 1980s, recognizing the specialized services and funding the agency, despite opposition by some community members.

Population Served

The clients of SCS self-identify in the following ways (according to 1998 client demographics):

Gender	Number of Clients
Female	235
Male	373
Male to Female	32
Female to Male	2
Other	1
Unknown	1
TOTAL	644

Age	Number of Clients
0-3	3
4-12	2
13-17	6
18-22	38
23-35	248
36-65	338
65 and over	5
Unknown	4
TOTAL	644

Race	Number of Clients
American Indian	22
Asian Indian	1
Chinese	3
Filipino	4
Korean	1
Vietnamese	3
Hawaiian	2
Other Asian / Pacific Islander	2
Other Race	10
White / Caucasian	520
Black / African American	42
Eskimo	1
Mixed Race – No Preferences	27
Not reported – Unknown	6
TOTAL	644

Scope of Services and Supports

SCS serves approximately 650 clients a year in its various mental health programs. These programs include, among others:

- *Adult Outpatient Services.* Individual, couples, group and family counseling services, including a free drop-in group for coming-out issues.

- *Children and Youth Services.* Services to children and youth who are struggling with their sexual orientation, identify as a sexual minority, are the child of a sexual minority or who are receiving shelter at a transitional housing unit where SCS provides mental health counseling and case management.

- *Older Adult Services.* Services for adults age 50 and older who identify as sexual minorities. This includes responding to the unique needs of adults who identify as "pre-Stonewall."

- *Spousal Support.* Individual and couples therapy for individuals who learn that their spouse from a heterosexual relationship is coming out as gay or lesbian.

- *Domestic Violence.* Perpetrator/Batterer Treatment within a licensed program and victim support services to male victims of same sex domestic violence through individual and group sessions. (Women who are victims of same sex domestic violence receive services at a sister agency.)

- *Psychiatric Services.* Psychiatric assessments and medication monitoring by a licensed psychiatrist and a psychiatric nurse practitioner.

- *HIV/AIDS Services.* In addition to individual and couples counseling, SCS provides groups on various topics to support people impacted by HIV/AIDS, including psychodrama groups. Many of the individual services are funded through Ryan White grants.

- *Transgender/Transsexual Services.* Counseling, both individual and group, for people exploring gender identity or who are in the process of meeting the Benjamin Standards to prepare for sex reassignment surgery.

- *Sexual Assault Services.* Through the use of city and state grants, individual and group counseling with specially trained clinicians is available to low-income clients who are survivors of child sexual abuse or sexual assault.

- *Connections Helpline.* The line that started SCS is still in service. The helpline is staffed almost entirely by community volunteers who have participated in extensive training. The line provides information, referrals and support to callers throughout the state, as well as throughout the country.

- *Internship Program.* An intensive internship program provides specialized training to graduate-level students from various programs in the Seattle area.

Culturally Competent Initiatives and Strategies

Seattle Counseling Service is a member of the Cross Cultural Alliance, a group of mental health provider agencies committed to culturally competent services in the King County mental health system, as well as throughout Washington state.

Sexual minorities are recognized by the King County Mental Health Division as one of the minority populations requiring specialized services. Providers serving clients within the Pre-Paid

Health System (Medicaid) must obtain consultation on treatment planning for all sexual minorities if they are not a designated Sexual Minority Mental Health Specialist.[1] SCS provides many of these consultations and trains specialists to provide consultation at other agencies.

Because Seattle Counseling Service is committed to providing culturally competent services to all clients, any client that identifies as a minority—racial / ethnic, older adult, child, deaf / hard of hearing, developmentally disabled or other—must have their treatment plan reviewed by a minority specialist representing these other identifications, in addition to the sexual minority specialist. This must be documented in the client file, with recommendations integrated into the treatment plan. The treatment plan is reviewed at least annually, more frequently if requested by the specialist.

Funding

The total budget for SCS is currently approximately $1 million. Primary funding for services includes:

- Medicaid funding,
- Ryan White funding, to support the provision of crisis and long-term counseling services to people with HIV or AIDS,
- United Way grants,
- City of Seattle and Washington state funding for victims of sexual assault and domestic violence, and
- Clients' private payment, including insurance funding.

Collaborative Efforts

SCS works closely and collaboratively with other minority specialist provider agencies, with providers serving people affected by HIV/AIDS, domestic violence providers and other mental health agencies throughout King County. SCS provides training and consultation to individual mental health providers and agencies throughout Washington state. SCS places a staff person at the Downtown Emergency Service Center to provide outreach and case management to the sexual minority homeless population in Seattle. In 1994, the Washington Department of Social and Health Services contracted with Seattle Counseling Service to provide training at a statewide conference for service providers. Many agencies throughout the state continue to contract with SCS for training and consultation.

[1]Minority Specialists in Washington state are required to have the following for certification: 100 hours of training or study on issues relevant to working with the population; equivalent of one year's full-time direct service with the applicable minority population under the supervision of a mental health professional who is a minority specialist for the same population; and evidence of ongoing training/study regarding relevant minority issues (8 – 16 hours per year).

Evaluation Efforts and Results

SCS is committed to increasing the amount of feedback available through performance outcome information and program evaluation. Current performance outcome information is provided through King County Mental Health Division and the managed care company that provides contract oversight for the county. Seattle Counseling Service consistently is found to provide high quality services, as documented through performance outcome measurement.

Services provided to those impacted by HIV/AIDS, which are funded by Ryan White grants, have been found to increase the level of functioning of individual clients, as well as to provide relief of negative mental health symptoms for most clients.

The provider-sponsored network in which SCS participates is working toward adopting a nationally recognized tool to measure performance outcomes consistently throughout the county. This will be completed by December of 1999.

SCS is currently preparing to apply for accreditation by the Commission for the Accreditation of Rehabilitation Facilities.

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Model Program:
Heights Hill LesBiGay and Transgender Affirmative Program, South Beach Psychiatric Center

Although most clinicians may have lesbian and gay consumers on their caseloads, sexual orientation and gender issues tend to be a peripheral focus when treating major mental illness.

Overview

The LesBiGay and Transgender Affirmative Program was established at the Heights Hill Outpatient Department of the South Beach Psychiatric Center, a New York State Office of Mental Health (NYSOMH) facility, to bridge the social and cultural gap experienced by lesbian, bisexual, gay and transgender consumers and their loved ones in a traditional mental health care setting. The need for such a program was identified as a result of staff experience with individuals who, because of their sexual orientation and mental illness, are subject to a dual discrimination. The perception exists that they are welcome in neither traditional mental health agencies due to their lifestyle nor in gay and lesbian agencies due to their serious mental illness.

In order to respond to this unmet need, staff members who were sensitive to these concerns and interested in participating as members of a core provider team were identified and assigned to the team.

Services are available to all chronically mentally ill individuals who identify themselves as lesbian, gay, bisexual or transgender in the greater New York City metropolitan area. Approximately 60 individuals have been served since the inception of the program in February 1996, the vast majority (90%) men. Thirty-five consumers are currently receiving active services.

Culturally Competent Initiatives

Since most consumers of service and clinicians in traditional community mental health settings are heterosexual, consumers who are lesbian, gay, bisexual and transgender often experience the mental health center as another part of the heterosexual culture. They feel less safe, less comfortable, less able to be open about their life style, more vulnerable to homophobia and heterosexism. Although most clinicians may have lesbian and gay consumers on their caseloads, sexual orientation and gender issues tend to be a peripheral focus when treating major mental illness. In addition, mainstream clinicians may not be comfortable or knowledgeable about assessing the circumstances and needs of sexual minority individuals and may be uncertain about appropriate treatment goals and strategies.

Interventions offered by the LesBiGay and Transgender Affirmative Program are geared to addressing the dual stigma associated with variant sexual or gender orientations and mental illness while fostering a sense of acceptance and community related to cultural minority status. In addition to traditional outpatient services, the program offers other culturally relevant activities including:

- *Weekly Support Group:* this group provides an opportunity for clients to share their personal experience and develop intimate connections with others at the interface between sexual minority status and serious mental illness.

- *Weekly Cultural Awareness Group*: this group encourages clients to explore their identity in relation to the larger lesbian, gay, bisexual and transgender community and culture, emphasizing an historical perspective in the building of a self-identity.

- *Monthly Coffee Klatch*: a monthly opportunity for sexual minority community socializing.

- *Weekly Reading Room*: various reading materials including relevant newspaper articles, brochures, and information on current events at the Lesbian & Gay Community Center are provided prior to the support group to foster awareness of events and issues in the community.

- *Sexual Minority Consumer Advisory Committee*: this committee of consumers evaluates programming and advises administration. Goals of this group include promotion of consumer activism and provision of a feedback mechanism to ensure that services remain relevant and effective.

- *Steering Committee*: a group of clinical administrators and staff oversee the structure and operation of the program.

- *Clinic Environment*: the program works to promote a "gay/transgender friendly" clinic environment with prominent placement of relevant posters, brochures and reading materials in various public areas of the clinic.

- *Yearly Gay/Transgender Pride Party*: an annual social event to celebrate sexual and gender diversity in a caring environment that promotes compassion and respect for those who struggle with major mental illness.

- *Other Cultural Events*: the LesBiGay & Transgender Program participates in South Beach Psychiatric Center's yearly Multi-Cultural Day events.

- *Staff Enrichment*: a regular speakers series is provided on sexual minority topics relevant to therapists who work with individuals with severe mental illness. The Program is "on-call" to all staff for consultation. In-service presentations to inpatient staff have been provided. The program's clinical focus was the subject of a recent grand rounds.

- *Student Training*: interested post-graduate psychology and social work students participate in the clinical and research components of the program under supervision during the academic year.

- *Research*: a collaborative project with the Institute of Health and Health Care Policy at Rutgers University is in progress.

- *Outreach*: a network of contacts and resources is maintained within the psychiatric and sexual minority communities.

- *Sexual Minority Client Focus*: psychoeducational interventions are conducted with the general client population that is served by the clinic to enhance understanding of sexual minority issues and of the prejudices against them.

Program staff represent an agency and community resource for information, education and consultation concerning the specialized issues involved in working with this minority group. The program also provides opportunities for student training.

Funding

The program was initiated with a $3,000 startup grant to support outreach and planning. At present, the Heights-Hill LesBiGay and Transgender Affirmative Program is supported entirely with funds from the New York State Office of Mental Health. It is advertised and run by staff volunteers. Efforts to obtain additional resources through foundation grants are currently underway. Additional funds will allow the program to expand staffing to reach more consumers and to further build a complete continuum of care for consumers.

Collaborative Efforts

A specialized continuum of care has been developed for consumers in conjunction with the Long Island College Hospital (LICH) for acute inpatient care, the Heights Hill inpatient unit for intermediate inpatient care and the Institute for Community Living (ICL), which provides residential services. A collaborative relationship also exists, which relies heavily on consumers as advocates and counselors, with Networks Plus for supportive employment services. Future plans call for intra-agency training and consultation as program staffing expands.

Evaluation Efforts and Results

The Heights Hill LesBiGay and Transgender Affirmative Program is involved in a joint research endeavor with Rutgers University to better understand and serve the needs of this specialized population. Early findings indicate that consumers feel helped and understood in ways that had not been available to them before. The program was designated an "Innovative Program" by the American Psychiatric Association in 1998.

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Model Program: Pride Institute

A recent University of Washington survey found that gay men and lesbians are four times more likely to consult mental health professionals than are heterosexuals. Yet among those who initiate treatment, roughly one quarter terminate feeling that they received "poor or inadequate" service from the provider.

Overview

Every treatment program has gay and lesbian clients. Among the millions of gay and lesbian Americans, substance abuse and emotional illness occur at similar rates to those of the general population. But access to culturally competent mental health services varies from region to region. Even in major cities where there are large gay populations, homophobic attitudes persist in much of the treatment community. A recent University of Washington survey found that gay men and lesbians are four times more likely to consult mental health professionals than are heterosexuals. Yet among those who initiate treatment, roughly one quarter terminate feeling that they received "poor or inadequate" service from the provider. More disconcerting, 46 percent of gays who seek treatment find themselves in the care of a psychotherapist whom they experience to be "homophobic." There may not be necessarily overt homophobic behavior so much as a cultural gap between therapist and client. A well-meant, albeit naïve, statement such as "you can tell me about your sexual preference but other staff or patients may not be as accepting" can scare a gay patient straight into the closet. Transgender individuals find it even harder to trust general adult psychiatric settings, where their treatment typically begins with a painful negotiation about the use of their male or female name and whether they will occupy a male or female room in an inpatient setting.

Pride Institute was founded in 1986 to provide gay and lesbian affirmative substance abuse treatment. The program began as a chemical dependency facility in Eden Prairie, Minnesota, and grew into a national consortium of dual-diagnosis programs. Program sites include: New York City/New Jersey, Chicago, Dallas and Ft. Lauderdale.

Pride Institute offers a full continuum of care for the entire spectrum of psychiatric and addictive disorders. According to program staff, the Minneapolis site continues to be the nation's leading chemical dependency facility dedicated to treating gays and lesbians. Each year the Pride admissions office in New York City receives approximately 5,000 inquiries on its "800" number from callers living as far afield as Anchorage, Alaska and Key West, Florida. The bulk of these callers—about two-thirds—simply require a referral for psychotherapy with a local, gay affirmative provider. Of the 1,800 callers who enter treatment at Pride, 65% meet criteria for dual-diagnosis treatment. About 25 percent present with only chemical dependency needs and 10 percent with only psychiatric needs. (The skew toward chemical dependency treatment

probably reflects a historical constituency and referral base more than it does the total distribution of mental health needs among gay Americans.)

Because of the broad scope of services offered, Pride Institute is able to treat gay, lesbian, bisexual and transgender individuals at all levels of care. A patient may present with an acute psychiatric and/or chemical dependency problem that requires inpatient hospitalization. As part of that procedure he or she may receive intensive individual therapy, psychoeducation and group psychotherapy, and, in some cases, couples or family interventions. If partial hospitalization is recommended, it is available at each Pride site. (At most sites, there is also the option of residence in a supervised, sober-living dormitory.) Intensive outpatient psychotherapy groups and chemical dependency groups are available as an interim step in a patient's transition to continuing in individual weekly treatment, if appropriate, or couples/family therapy, which may be provided by an associated practitioner or agency.

Culturally Competent Strategies

Pride Institute's founders sought to broaden the 12-step recovery model to encompass aspects of the gay, lesbian, bisexual and transgender (GLBT) experience that were felt to be devalued or, at best, deferred in traditional treatment contexts, including:

- coming out difficulties,
- sexual addictions,
- family/relationship/parenting problems,
- gender issues,
- cultural victimization/anti-gay or lesbian violence,
- HIV-related complications, and
- grief and bereavement.

"Old timers" in the program would instruct new participants to "focus on recovery" rather than address these concerns. Pride's strategy was to greet people new to recovery by acknowledging these problems. These critical moments in a gay person's life story were used to frame the tasks involved in "recovery." Psychosocial stressors related to living a gay, lesbian or transgender lifestyle, and also thriving in one, were used as benchmarks that people could use to assess their experience of addiction or emotional wellness. From this starting point, clients were more receptive to traditional medical and psychiatric interventions.

Pride services expanded to include psychiatric, dual-diagnosis care when it was observed that clients had masked emotional and behavioral health problems during prior admissions in general psychiatric contexts. Patients said, for example, "I was afraid to speak in groups with straight patients," "the treatment plan included homosexuality as a problem area," and "I was paranoid that someone would hurt me if they found out." Patients with psychotic disorders were not being well served. People with schizophrenia may have been seen as "too undeveloped" to have a

sexuality—although they were homosexually active. Sexual compulsivity might be misdiagnosed as a symptom of bipolar disorder, hypomania might be dismissed as histrionic behavior and personality disorders may go untreated for fear of being charged with homophobia. In other cases, an otherwise appropriately treated individual may leave the hospital never having had the experience of working with a therapist whom they could identify as a mentor.

Treatment begins with a thorough evaluation. Clients who are asked about aspects of sexual intimacy and relational practices in a candid way by a member of the GLBT community often disclose more significant information about psychiatric symptoms than they might otherwise. Psychopharmacological and psychotherapeutic treatment can be planned at the appropriate level of care, and psychosocial problem areas can be honed to reflect difficulty adjusting to gay cultural norms (which may differ from normative, heterosexual norms). Group and individual treatment has been designed to incorporate milieu-based treatment, 12-step and cognitive behavioral techniques. Psychoeducation on gay and lesbian developmental issues complements relapse prevention and makes each treatment experience richer. Patients (all GLBT but otherwise quite different) are exposed to people with a wide range of problems. Whether they have addiction issues, mental health concerns or both, according to program staff patients leave Pride with a greater sense of the diversity of GLBT experiences. Often this frees them of the sense of being a stereotyped gay character and helps them see the integrity of their individuality.

Collaborative Efforts and Funding

Pride Institute is a private corporation that operates in collaboration with the free-standing psychiatric hospitals where its programs are housed—some are privately owned, others operate as not-for-profit foundations. A figure representing the total budget is not calculable because the separate sites are associated with varying institutions. Funding arrangements differ in each case depending on the host site's ability to access Medicare, Medicaid, commercial insurance plans and managed care reimbursement. While the Minneapolis site is owned by Pride Institute and serves only GLBT clients, other programs share hospital facilities with other psychiatric programs. Pride Institute collaborates closely with the host institutions' medical, nursing and finance directors to develop appropriate policies for medical and billing procedures. Pride Institute's Alumni Foundation has offered small grants for public education programs. Pride Institute also works closely with a number of employee assistance organizations to facilitate access to treatment for their GLBT clients.

Each program has its own staff and milieu. Treatment settings are filled with symbols of gay and lesbian awareness, GLBT news and style magazines, and libraries of gay and lesbian novels and films. Dress, while professional, signals proud participation in gay and lesbian codes of self-representation. Pride makes great efforts to create partnerships with community, state and educational agencies that serve program patients and plays an important role in patient aftercare. Patients are typically introduced to these services as part of their treatment. In addition to alliances with local gay and lesbian organizations and HIV consortia, Pride Institute works with

a broad network of local gay and lesbian affirmative health practitioners. Admissions staff also help many callers who do not require Pride services with appropriate referrals to gay affirmative counselors or other health providers.

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www.pride-institute.com

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Organizations

The Action Council for Cross-Cultural Mental Health and Human Services, Inc.
The Action Council
P.O. Box 1695
Columbia, SC 29202
(803) 734-6475
The Action Council for Cross-Cultural Mental Health and Human Services, Inc. is a voluntary organization dedicated to enhancing the involvement of minority citizens in the management, delivery and utilization of mental health and human services. A dues-collecting, membership organization, the Action Council provides programmatic and policy consultation and training for managers and decision makers, and promotes education in understanding diverse cultures. The Action Council sponsors an annual conference in conjunction with the South Carolina Department of Mental Health and other organizations.

The African American Family Services Technical Assistance Center
2616 Nicollet Avenue South
Minneapolis, MN 55408
(612) 871-7878
http://www.aafs-mn.org
Contact: Tasselean Parker
A division of a multi-faceted community-based agency offering mental health and chemical health services, the Technical Assistance Center creates training programs for counselors, agency administrators and boards of directors and other service professionals throughout the United States. Participants receive tools and techniques to enhance and improve service delivery to African American clients.

African American Mental Health Research Center
Institute for Social Research — Program for Research on Black Americans
University of Michigan
426 Thompson, Room 5118
Ann Arbor, MI 47106
(734) 763-0045
http://www.isr.umich.edu/rcgd/prba
The National Institute of Mental Health provided funding to help start this research center to study African American mental health issues and evaluate the way African Americans seek help for mental illness. The Center's interests include child and adolescent mental health and serious mental illness in urban areas.

AIDS Mental Health Training Program
UCLA Center for Health Promotion and Disease Prevention
Center for Health Sciences, Room 61-236
10833 LeConte Avenue
Los Angeles, CA 90095-1772
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The CMHS-funded AIDS Mental Health Training Program (AMHTP) at UCLA offers HIV knowledge- and skill-based training tailored to mental health providers and health educators who work with people with serious mental illness. AMHTP training programs provide extensive information about HIV and AIDS, as well as experiential training to practice prevention and intervention skills. AMHTP trainings address the unique challenges of communicating about and treating HIV-related concerns among mental health service consumers.

American Counseling Association, Association for Multicultural Counseling and Development (AMCD)
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Established in 1972 under the American Counseling Association, the AMCD works to develop an efficient and effective system of organizational management, enhance existing professional standards and promote and expand culturally competent research and knowledge.

American Psychiatric Association (APA)
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202-682-6097
Contact: Janice Taylor
The APA Committee on Lesbian, Gay and Bisexual Concerns is charged to investigate problems and issues in lesbian, gay and bisexual mental health care such as stigmatization and discrimination. They offer teaching programs to help overcome the inadequate training most psychiatrists have received regarding homosexual concerns. The APA also promotes education of the APA membership and the general public regarding homosexuality.

American Psychological Association (APA)
Division 44, Gay and Lesbian Concerns
729 Boylston Street, 4th Floor
Boston, MA 02116
(617) 262-0315
www.apa.org/about/division/div44.html
Contact: Douglas M. Deville, PsyD
The APA Division 44, addressing gay and lesbian concerns, focuses on the diversity of human sexual orientations by supporting research, promoting relevant education, and addressing professional and public policy. It has task forces on accreditation, bisexuality, professional standards, public policy, youth and families, ethnic/racial issues, and science and research. Division 44 publishes a newsletter three times a year and a program describing Division 44's activities for distribution at the annual APA convention.

American Psychological Association (APA)
Office of Ethnic Minority Affairs
750 First Street, NE
Washington, DC 20002-4242
(202) 336-5500
www.apa.org/pi/oema/homepage.html
The APA Office of Ethnic Minority Affairs (OEMA) seeks to promote scientific understanding of the influences of culture and ethnicity on behavior, encourage increased public knowledge of the special psychological resources and mental health needs of communities of color, and increase the number and participation of ethnic minority psychologists in the discipline and the Association. In support of these objectives, OEMA's activities include maintaining and editing the *Directory of Ethnic Minority Professionals in Psychology*, operating a minority job bank and publishing *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations.*

Asian and Pacific Islander Health Forum
942 Market Street, Suite 200
San Francisco, CA 94102
(415) 954-9988
www.apiahf.org
Contact: Tessie Guillermo
A national advocacy, policy and research organization dedicated to improving the health of Asian and Pacific Islander Americans. The Health Forum offers publications and fact sheets on all aspects of Asian and Pacific Islander health including mental health. The Forum also maintains a closed and moderated mailing list as an information and referral point for individuals and organizations that provide alcohol, substance abuse and mental health services.

Gay, Lesbian, Bisexual and Transgender Health Access Project
JRI Health
100 Boylston Street, Suite # 860
Boston, MA 02116
(617)988-2605
Contact: Jan Platner
www.glbthealth.org
The Gay, Lesbian, Bisexual and Transgender (GLBT) Health Access Project, in partnership with the Massachusetts Department of Public Health, works to foster the development of comprehensive, culturally appropriate health promotion policies and health care services for gay, lesbian, bisexual and transgender people through a variety of venues including community education, policy development, advocacy, direct service and prevention programs. GLBT Health Access recently published "Community Standards of Practice for the Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgender Clients." These Community Standards offer detailed guidelines for making health and mental health services accessible and culturally appropriate for GLBT persons. Training and technical assistance regarding the use of these guidelines is now being provided to service settings throughout Massachusetts through the Fenway Community Health Center.

Georgetown University Child Development Center
National Technical Assistance Center for Children's Mental Health
3307 M Street, NW, Suite 401
Washington, DC 20007
(202) 687-5000
http://knsrv01.iaims.georgetown.edu/depts/pediatrics/gucdc_
Contact: Marva Benjamin, Director, Cultural Competence Initiative
The mission of the Georgetown University Child Development Center is to improve the quality of life for children with special needs and their families. Products and services include information packets, issue briefs and monographs on children and adolescents with serious emotional disturbances; conferences and training institutes on planning, delivery and financing of services; consultation on systems change and services development and delivery; and agency and organizational collaboration.

Multi-Ethnic Mental Health Consortium Resource and Training Center
17 S. High Street, Suite 1015
Columbus, OH 43215
(614) 228-2220
www.mebhc.com
Contact: Marty Miller
The Training Center provides advocacy and training on cultural diversity and mental health issues relevant to the needs of African American, Asian, Hispanic and Native American residents of Ohio.

National Association of Social Workers (NASW)
National Committee on Lesbian, Gay and Bisexual Issues (NCLGB)
750 First Street, NE, Suite 700
Washington, DC 20002
202-408-8600 (phone)
202-336-8310 (fax)
www.socialworkers.org
Contact: Evelyn P. Tomaszewski, ACSW
NCLGB works to promote the development of knowledge, theory and practice as related to gay, lesbian and bisexual issues; to identify ways to eliminate homophobic social work practices and policies (e.g., so-called reparative therapies); and to assist the association and the larger profession in developing lesbian, gay and bisexual affirming policies, procedures, and programs. NASW supports curriculum content that affirms lesbian, gay, and bisexual people; encourages implementation of relevant continuing education; strives for full representation of lesbian, gay, and bisexual people at all levels of leadership and employment in social work; and advocates for and encourages efforts to end violence and discrimination towards gay, lesbian, and bisexual people.

National Center for American Indian and Alaskan Native Mental Health Research
University of Colorado Health Sciences Center, Department of Psychiatry
4455 East Twelfth Avenue, Campus Box A011-13
Denver, CO 80220
(303) 315-9232
www.uchsc.edu/sm/ncaianmhr
Contact: Spiro Manson, Ph.D. Director
Funded by the National Institute of Mental Health, the National Center for American Indian and Alaskan Native Mental Health Research focuses on research, research training, information dissemination and technical assistance for American Indian and Alaskan Native populations. The Center has developed a computerized bibliography on Indian and Alaskan Native mental health and a resource directory that inventories individuals, programs and agencies with expertise in mental health research, service and education specific to Indian and Alaskan Native communities.

The National Coalition of Hispanic Health and Human Services Organizations
1501 16th Street, NW
Washington, DC 20036
(202) 387-5000
www.cossmho.org
Contact: Jane Delgado, President
The Coalition is a nonprofit membership organization dedicated to improving the health and psychosocial well-being of the nation's Hispanic population by conducting national demonstration programs, coordinating research and providing information, technical assistance

and policy analysis. More than 700 member organizations provide community-based health, mental health, substance abuse and social services.

National Council of La Raza (La Raza)
111 19th Street, NW, Suite 1000
Washington, DC 20036
(202) 785-1670
www.nclr.org
Contact: Helen Coronado
La Raza is a private, nonprofit organization established in 1968 to reduce poverty and discrimination and improve opportunities for Hispanic Americans. La Raza works toward this goal primarily through capacity-building assistance to support and strengthen Hispanic community-based organizations; promoting applied research, policy analysis and advocacy to provide a Hispanic perspective on issues such as education, housing, and health; and encouraging the adoption of programs and policies that equitably serve Hispanics.

National MultiCultural Institute
3000 Connecticut Avenue, NW, Suite 438
Washington, DC 20008-2556
(202) 483-0700
www.nmci.org
Contact: Elizabeth Salett, President
A non-profit organization located in Washington, D.C., NMCI offers diversity training, sponsors multicultural conferences, produces educational resource materials and provides multicultural counseling and referral services.

National Research Center for Asian American Mental Health
Department of Psychology - University of California
One Shield Avenue
Davis, CA 95616-8686
(503) 752-1400
http://psychology.ucdavis.edu/asianamerican/nrcaamh.html
Contact: Stanley Sue, Ph.D.
Sponsored by the National Institute of Mental Health, the National Research Center for Asian American Mental Health conducts prevalence studies among Asian Americans and Pacific Islanders. The Center also studies mental health treatments, including assessment instruments and social networks.

Office of Minority Health Resource Center
P.O. Box 37337
Washington, DC 20013-7337
(800) 444-6472
TDD 301- 589-0951
www.omhrc.gov
The Minority Health Resource Center is a national resource and referral service for minority health issues that provides information on funding sources and community programs. The Center's newsletter, "Closing the Gap," is available free of charge. A customized data base searches health resources for African Americans, Asian Americans, Pacific Islanders, Latinos, and Native American populations.

Substance Abuse and Mental Health Service Administration (SAMHSA)
Pacific Islander Initiative
Center for Substance Abuse Treatment
Suite 880, Rockwall II
5600 Fishers Lane
Rockville, MD 20857
(301)443-9396
www.samhsa.gov
SAMHSA collaborates with consumers and constituents, including Asian American and Pacific Islander communities, to improve the quality and availability of prevention, treatment and rehabilitation services in order to reduce illness, death, disability and cost to society resulting from substance abuse and mental illnesses. Much of SAMHSA's work, service to, and communication with Asian Americans and Pacific Islanders has been through interactions with community-based groups and National organizations like the National Asian Pacific American Families Against Substance Abuse, Inc.(NAPAFASA), Asian and Pacific Islander American Health Forum, Inc.(APIAHF), Association of Asian/Pacific Community Health Organizations (AAPCHO), Asian Americans and Pacific Islanders for Health Promotion, Inc. (AAPIHPI), Asian American Prevention Cluster Group, Pacific Islands Officers Association and others.

The Transgender Education Network (TEN)
JRI Health, TEN
100 Boylston Street, Suite 860
Boston, MA 02116
617-988-2605, ext. 211
www.jri.org/transhealth
Contact: A.D. Marcel, Director
TEN, a project of JRI Health, has established a program dedicated to addressing the health care needs of the transgender community. While generating the latest health information, research and referrals, they also provide trainings and education to social services providers, teachers, clinics and employers. TEN support services include: technical assistance, in-service training, regional

trainings, HIV/AIDS street outreach, support groups, community events, and a Trans Health Committee.

Western Interstate Commission on Higher Education (WICHE)
Mental Health Program
P.O. Box 9752
Boulder, CO 80301-9752
(303) 541-0250
www.wiche.edu
Contact: Jim Stockdill, Ph.D.
WICHE is a public interstate agency established to promote and facilitate resource sharing, collaboration and cooperative planning among the western states for higher education and work force needs. Member and affiliate states include Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming.

Web Sites

APA Division 44, Gay and Lesbian Concerns
www.apa.org/divisions/div44
Focuses on the diversity of human sexual orientations by supporting research, promoting relevant education, and addressing professional and public policy. The Division's web site includes information on human sexuality, answers to questions regarding sexual orientation and information on APA policies related to sexual minorities.

Asian Community Mental Health Services (ACMHS)
www.acmhs.org
ACMHS provides an array of culturally competent specialized services that include supportive behavioral health care services, and substance abuse prevention and treatment for at-risk youth. The organization's publications include educational brochures on prevention and clinical issues in several Asian languages.

Diversity Rx
www.diversityrx.org
Funded by the National Conference of State Legislatures, Resources for Cross Cultural Health Care and the Henry J. Kaiser Family Foundation of Menlo Park, CA, Diversity Rx seeks to educate health care providers, provide a repository of information and resources for anyone developing or promoting linguistically and culturally appropriate services, and to promote communication and information exchange among experts and others interested in the topic. Their web site includes demographic information, models and practices, policy information, and additional resources.

Gay, Lesbian, Bisexual and Transgender Health Access Project
www.glbthealth.org
The Gay, Lesbian, Bisexual and Transgender Access Project, in partnership with the Massachusetts Department of Public Health, works to foster the development of comprehensive, culturally appropriate health promotion policies and health care services for gay, lesbian, bisexual and transgender people. Results of needs assessments, focus group research and newly developed standards of care are available on this web site.

Indian Health Service
www.ihs.gov
As the federal agency that addresses the physical and mental health needs of Native Americans, the Indian Health Service hosts an Internet home page that provides information on the agency, helpful publications and links to other Native American-related web sites.

International Association for Cross-Cultural Psychology
www.fit.edu/CampusLife/clubs-org/iaccp
Founded in 1972 with membership of more than 500 professionals in more than 65 countries, IACCP aims to facilitate communication among persons interested in cross-cultural psychology and to examine more effectively the universal validity of psychological theories in all branches of psychology and related disciplines. Its web site contains information on IACCP's international congresses, regional meetings and relevant publications.

NativeWeb
www.nativeweb.org
This comprehensive site describes its purpose as "providing a cyber-place for Earth's indigenous peoples." NativeWeb features information on many subject categories (including health and mental health), newsletters and journals, bibliographies and historical material.

Transgender Education Network (TEN)
www.jri.org/transhealth
TEN has established a program dedicated to addressing the health care needs of the Transgender community. Together with JRI Health Information System, TEN has developed an on-line transgender health site to provide accessible information and resources.

Torture Survivors Network
http://pacinfo.com/eugene/tsnet/index.html
The Torture Survivors Network is a forum for survivors' voices, for exchange of information between treatment center professionals, for those interested in starting a program in their own community and for the general public. The Network's home page contains an information exchange, history of torture and survivors testimonies.